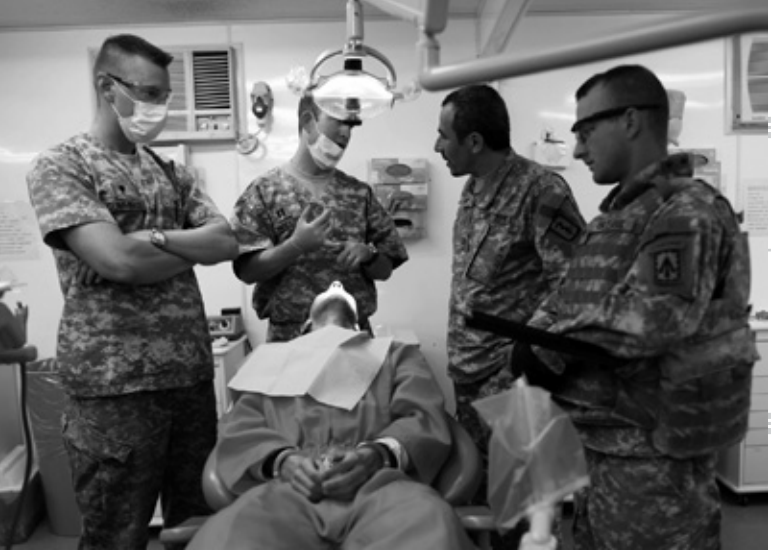

DETAINEE HEALTHCARE as part of INFORMATION OPERATIONS

Lieutenant Colonel Beverly D. Patton, U.S. Army

DURING TIMES OF CONFLICT, the United States has always provided healthcare to detained persons, prisoners of war, and displaced civilians. But ever since 9/11 and in the wake of the Abu Ghraib prison scandal in Iraq, detainee healthcare has become a strategic mission. The legacy of Abu Ghraib created a powerful negative image not only in the minds of those in the Muslim world, but also worldwide, thereby damaging the United States' political international standing. Among the four instruments of national power—diplomacy, information, military, and economic—the United States can use the instrument of information to educate and persuade others, clarify America's position, and project positive images that help accomplish its strategic goals. Providing detainee healthcare can create such positive images, helping to win "hearts and minds" through services and training that are not otherwise readily available in a war-torn country.[1]

Over the past 90 years, the United States has been involved in the two World Wars and five other major conflicts: Korea, Vietnam, Desert Storm, Afghanistan, and Iraq. In each conflict, America has provided care for prisoners of war or detained persons, and rendered that care as part of the operations of war. Wartime necessity and experiences, previous practices, and the Geneva Conventions have guided detainee care. Such care has been particularly challenging during the current conflict in Iraq. United States forces were supposed to turn the governing of Iraq over to a new, pro-democratic government and depart once Saddam Hussein was captured.[2] The United States expected that the lion's share of rebuilding would fall to the Iraqis themselves, and many war-related issues such as prisoners of war and detained persons would be under the purview of the new Iraq government.[3] But what started as a conventional war between professional, uniformed militaries became an insurgency.

This faulty assessment of how the war would unfold, coupled with the American failure to provide enough troops to quell the insurgency, led to the detention of thousands of Iraqis.[4] The Abu Ghraib prison scandal forced the United States to initiate efforts to overcome the negative perception of how America cares for its detainees.[5]

Detainee Healthcare in Previous Conflicts

The United States has been involved with detainee and prisoner of war (POW) care in conflicts throughout its history. During the Civil War, both

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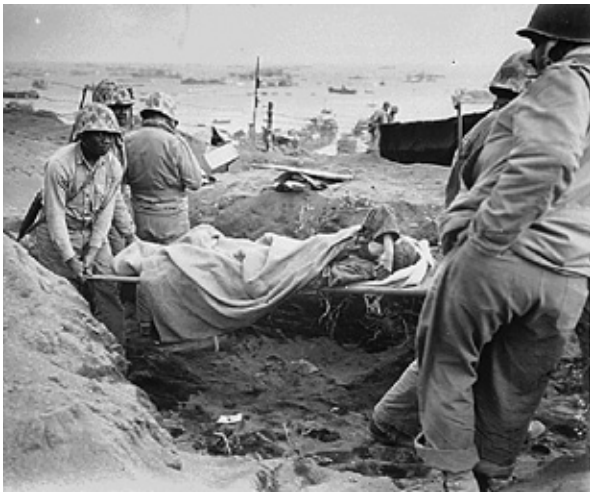
PHOTO: An inmate is ready for dental work at a US military detention facility, Camp Bucca, Iraq, 17 March 2009. (AP Photo, Dusan Vranic)

the Union and Confederacy established POW camps. The Union camp in Elmira, New York, and the Confederate camp in Andersonville, Georgia, had the largest number of detainees. Both camps had challenges caring for its prisoners.[6] At the Elmira camp, severe winters and a poor drainage system exacerbated difficult living conditions, and an inadequate diet with few vegetables led to cases of scurvy. Eventually, many prisoners died of illness, exposure, and related causes. The Confederate prison at Andersonville had similar losses. While Elmira suffered the throes of severe winters, Andersonville presented the opposite conditions—searing heat and no shelter. As in Elmira, a fetid body of water ran through the camp, and prisoners used it for both bathing and drinking. The environmental conditions, coupled with poor sanitation and diet, led to dysentery, scurvy, malaria, and illness from exposure to the elements. Medical care was largely nonexistent. However, poor management and a lack of resources played a larger role in creating life-threatening conditions at this camp than did any intentional effort to abuse prisoners.[7]

The various countries involved in World War I promised to adhere to the Hague rules of fair treatment, the precursors of the current Geneva Conventions. An estimated eight million men were incarcerated during World War I, but a much smaller percentage of prisoners died than in the U.S. Civil War because the International Red Cross and individuals from neutral countries inspected prisoner-of-war facilities.[8]

Conditions for prisoners of war during World War II were actually much worse than in World War I. The Geneva Convention of 1929 was applicable to the conflict, but Japan was not a signatory to it. The International Red Cross had no access to prisoners in Japanese camps where the Imperial Army held POWs from Australia, Canada, China, Great Britain, New Zealand, the Netherlands, and the United States. Prisoners were subjected to ritual murder, beatings, harsh treatment, forced labor, medical experimentation, lack of food, and poor medical care. Treatment in other countries' prisoner-of-war camps varied. Both Germany and the Soviet Union intentionally abused each other's prisoners. The American experience with prisoners of war in World War II varied from region to region. Each facility had a medical clinic with monthly medical evaluations,



NARA

U.S. Marines carrying a Japanese prisoner to be evacuated and treated for malnutrition, Iwo Jima, February 1945.

and the food was comparable to that consumed by American Soldiers. After the war ended, captured German medical personnel administered health care to their countrymen while U.S. forces supervised. The United States provided little of its own direct care to the captives themselves. Due to poor field sanitation, diseases such as typhus, dysentery, and malaria arose along with other health problems. Insufficient infrastructure and the poor health of the few Japanese soldiers taken prisoner hampered American efforts to care for prisoners in the Philippine POW camps. There, malaria, dysentery, and poor hygiene created significant problems.[9]

At the outset of the Korean War, from August to November 1950, the number of prisoners of war swelled to a staggering number. There were not enough guards to control the prisoners, and prison food, clothing, and shelter were inadequate. In January 1951, the United Nations Command established a large prison at Koje-do Island, off the coast of South Korea, and tasked the United States to run the prison. It eventually housed five times the facility's intended capacity. Guard training varied, and at one crucial point, the camp commandant was taken hostage. The Red Cross was present during the reconstruction and reorganization of Ko-je do and other POW camps, and questioned some of the tactics that United Nations camp commanders used to control the prisoners .[10]

During the Vietnam War, North Vietnamese prisoners lived in a similar island prison in the Con-Dao Islands off the South Vietnamese coast. While U.S.

forces did not directly oversee the prison, they did provide advisors for the facility. Abuses by South Vietnamese guards came to light in the 1960s. Congressmen investigated these allegations when they visited the prison in 1970, and *Life* magazine published the photos that were taken.[11]

In two articles that were published in *Military Medicine* in December 1991, Army physicians described their experiences while administering medical care to POWs during Operation Desert Storm.[12] The articles were noteworthy for the doctors' concise descriptions of the prisoners' medical, surgical, and dental conditions, and their recommendations regarding future POW healthcare. The first article reported that more than 20 percent of the prisoners were on sick call, and many Iraqi prisoners wanted to have "injuries sustained in previous conflicts evaluated by [the] American doctors."[13] The second article described problems caused from inadequate medical staffing and the "lack of simple equipment most physicians normally take for granted."[14] It added, "The overwhelming number of prisoners resulted in the camps not being able to adequately feed or house several hundred prisoners at any given moment." Furthermore, while the most common complaint was trauma, then toothache, other afflictions included—

> …upper respiratory infections, headaches, urinary tract complaints, skin diseases, diarrhea, dyspepsia, backache, and hemorrhoids. The detainees had a variety of psychiatric complaints, including insomnia, anxiety, and frank depression, as well as nicotine-withdrawal symptoms. A number of medical conditions were seen unexpectedly…The Iraqi army did little or no medical screening [and] insulin-dependent diabetes, Parkinson's disease, schizophrenia, and number of other conditions were encountered.[15]

Operation Iraqi Freedom

Despite these historic (and as it turned out, prophetic) observations, problems with detainee care during Operation Iraqi Freedom mirrored that of previous conflicts and, in particular, the problems seen in Korea on Ko-je do Island.[16] The ability of U.S. forces to control the detainees, much less care for them, was made more difficult by a rapid influx of prisoners, an inadequate number of guards, a lack of detainee operations training for personnel, and the added complication of various religious, tribal, and ethnic groups who fought not only their captors, but also each other.[17]

The few medical personnel working at Abu Ghraib in 2003 and 2004 noted inadequate supplies such as chest tubes, catheters, orthopedic casts, and other items used to treat injuries.[18] A physician's assistant stated that U.S. personnel took chest tubes from deceased persons and inserted them into live ones because of a shortage of such medical supplies.[19]

The Independent Panel to Review DOD Detention found "significant shortfalls in training and force structure for field sanitation, preventive medicine, and medical treatment requirements for detainees."[20] The panel recommended that "as the DOD improves detention operations force structure and training, it should pay attention to the need for medical personnel to screen and monitor the health of detention personnel and detainees."[21]

The Army Surgeon General disputed some of the findings regarding medical care.[22] However, he noted that the Army had launched a review of medical detainee operations and delineated a policy for record keeping and the training of all Army medical personnel in detainee medical operations.

The assistant secretary of defense for health affairs provided guidelines for detainee care in June, 2005.[23] The standard of care for detainees was to be the same as that received by American and coalition forces. The 10-page-long Department of Defense Instruction (DODI) 2310.08E, *Medical Support for Detainee Operations*, sets forth guidelines for the Armed Forces Medical Examiner as well as behavioral science consulting, incident and consent for treatment reporting, and medical record keeping.[24]

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Other guidance issued or reviewed included Army Regulation 190.8, *Enemy Prisoner of War, Retained Personnel, Civilian Internees and Other Detainees*; Field Manual Interim 4-02.42, *Medical Support to Detainee Operations*; and the chapter on "Care of Enemy Prisoners of War/Internees" in *Emergency War Surgery*.[25] All of these documents define aspects of detainee medical care.

In April 2005, a full combat support hospital deployed to Abu Ghraib to care for detainees; two separate theater internment facilities became operational: Camp Bucca in southern Iraq and Camp Cropper in Baghdad. Additionally, the prison at Abu Ghraib closed. At each site combat support hospitals opened with and were augmented by over 200 medical professionals from an area support medical company, a ground ambulance medical company, and Romanian Army healthcare professionals.[26] The hospitals had "task-organized" force structures which incorporated medical specialties not always included in the tables of organization for such hospitals. Additionally, specialty care that was not provided at the theater internment facility was accessible from other regional combat support hospitals.

The combat support hospitals have taken on additional roles as well. Because public healthcare in Iraq has significantly declined over the past few years and sectarian strife prevails, the combat support hospital has also become a medical training facility for future theater internment facilities and Iraqi military medics and civilian nursing assistants.[27]

Just War and the Geneva Conventions

The morality of war, its initiation, and its conduct should be a constant concern for civilian and military leaders. Two separate concepts have developed over the centuries: *jus ad bellum,* the justice of going to war; and *jus in bello*, law during war itself. *Jus in bello* is the philosophical and traditional basis for how the United States conducts war. Military and civilian leaders decide the rules of engagement, which targets to attack or avoid, and how to deal with prisoners of war. Their decisions affect those who must enforce these rules: warfighters at all levels .[28]

The military leader must comprehend both the *jus ad bellum* and *jus in bello* concepts. Martin L. Cook states that military officers "set the tone for how civilians are treated, how POWs are captured, confined and cared for. They determine how Soldiers who violate order and the laws of war are disciplined and what examples they allow to be set for acceptable conduct in their commands."[29] Therefore, military leaders need to incorporate the concepts' tenets into every phase of planning and executing war.[30]

Military leaders must evaluate two moral demands in *jus in bello*: discrimination (combatant status) and proportionality. The distinction between combatants, those who are a legitimate target of war fighting, and non-combatants, those who should be spared intentional attack, is critical. However, when combatants do not wear uniforms, children detonate bombs, and contractors perform not only support but warfighting functions, it is difficult to determine who is a legitimate combatant and who should be protected.[31]

The principle of proportionality is a part of *jus in bello* decisionmaking. What is the value of a target when measured in proportion to the amount of destruction and loss of life required to destroy it? Should we avoid attacking specific targets just because they might be of use when hostilities end?[32]

Cook argues that comprehending and applying the principles of *jus ad bellum* and *jus in bello* and the Geneva Conventions are strategic leader competencies for the conduct of war.

The first Geneva Convention in 1863 adopted as principles the neutrality of military hospitals and ambulances and the non-belligerent status of individuals caring for wounded and sick Soldiers of any nationality.[33] The current Geneva Conventions date from 1949 and relate to sick and wounded combatants on land, on the sea, or shipwrecked; and they protect both prisoners of war and civilians in war.[34]

Political Instruments of Power and the Strategic Role of Detainee Healthcare

As aforementioned, the U.S. uses four instruments of national power—diplomacy, information, military, and economic—to accomplish national strategic goals. They are the "tools . . . the United States uses to apply its sources of power."[35] The U.S. government controls information to protect national security. The government can use strategic communication

to deliver guidance in specific instances. The military plays a role in strategic communication when it supports public and military diplomacy activities, and uses information operations, public affairs, and defense support to public affairs.

Joint Publication 1 notes that strategic communication should be a part of all military planning, written into operation plans, and carefully ordered with other government entities, coalition partners, and civilian organizations.[36] A paper from the Program in Arms Control, Disarmament, and International Security at University of Illinois asserts that information was once an "ancillary instrument of power," but now it is a decisive element in economic and military campaigns.[37]

Joint Publication 3-13, *Information Operations*, elaborates on the role of information in military operations. The publication states, "at all levels, information activities, including IO [information operations] must be consistent with broader national security policy and strategic objectives."[38] The publication also defines strategic communication as—

> …focused U.S.G. [United States Government] efforts to understand and engage key audiences in order to create, strengthen, or preserve conditions favorable for the advancement of U.S.G. interests, policies, and objectives through the use of coordinated programs, plans, themes, messages, and products synchronized with the actions of all elements of national power.[39]

An issue paper at the Center for Strategic Leadership noted that counterinsurgency operations in Iraq constituted a different type of war with less emphasis on "kinetic warfare" and greater concentration on information operations as the main effort.[40] The U.S. government faces significant challenges in reaching and affecting public opinion in the Middle East. In 2004, a State Department advisory group said, "The apparatus of public diplomacy [of which information operations is part] has proven inadequate, especially in the Arab and Muslim world."[41] A recent report from the Pew Global Attitudes Project concluded that the American image "remains abysmal in most Muslim countries in the Middle East and Asia." Polling of citizens in five Muslim countries (Egypt, Turkey, Jordan, Pakistan, and Indonesia) found that less than 33 percent held a favorable image of the United States.[42] (The Project asked a series of questions that included, "Have you heard about Abu Ghraib/Guantanamo abuses?")

The Bush administration tapped both an advertising executive, who was also a former diplomat, and the executive's director of strategic communications to execute public diplomacy to influence Middle Eastern audiences. However, the "Madison Avenue" approach and a careless lack of knowledge about the target audience that they wished to influence hurt U.S. efforts.[43] Secretary of Defense Robert Gates has recommended "a dramatic increase in spending on the civilian instruments of national security—diplomacy, strategic communications, foreign assistance, civic action and economic reconstruction and development."[44] The creation of Alhurra, an Arabic satellite television station sponsored by the U.S. government, has also failed to advance U.S. political aims. Caught in the politics of those in the United States who oversee and fund it, Alhurra has been viewed with skepticism in the Middle East and lacks the credibility of other Arab stations like Al Jazeera and Al-Arabiya.[45]

Perhaps a better way to reach to the target audience is the method outlined in FM 3-24, *Counterinsurgency*:

> Treat detainees professionally and publicize their treatment. Arrange for host-nation leaders to visit and tour your detention facility. Consider allowing them to speak to detainees and eat the same food detainees receive. If news media or host-nation government representatives visit your detention facility, allow them as much access as prudent. Provide a guided tour and explain your procedures.[46]

Major General Douglas Stone, Commander, Task Force 134, Detainee Operations, adopted such an approach when he took three representatives of the Iraqi media to Camp Bucca, the largest detainee camp in Iraq. He allowed the representatives to film some detainee operations and introduced them

…the "Madison Avenue" approach and a careless lack of knowledge about the target audience…hurt U.S. efforts.

to detainees. The Iraqi media toured the camp hospital and interviewed healthcare providers who described typical care regimens and emphasized that Iraqi detainees received the same level of care as American and coalition forces.[47]

Stone later had a U.S. military strategic communications director and native Middle Eastern media consultants help disseminate his message, which stressed transparency, care and custody, release, and the rule of law. Detainee health care fell into the care category, and Stone explained that while the physical care of detainees (shelter and food) was intuitive, civilian Iraqis had to see for themselves that the medical care was indeed equivalent to that of American and coalition forces before they would believe that it was true.[48]

Recommendations

Detainee healthcare has been a continuing mission for American military forces in every conflict. In the Iraqi conflict, military medical personnel have also taken on the role of training other elements of Iraqi society to provide additional numbers of native medical practitioners. However, detainee healthcare may well exert its strongest role as part of the information instrument of U.S. national power. Medical care benefits more than just the individual Iraqi. The dissemination of such positive messages about the medical care of detainees through a program of strategic communications can further U.S. political goals.

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The Iraqi media has broadcast news clips of detainee healthcare operations, but this has not often happened elsewhere in the Middle East. The impact of such positive messages would be greater if Arab news networks distributed them throughout the Middle East. Engaging the Arab networks requires careful crafting of the message, but the potential exists to reach a wider Middle Eastern audience and demonstrate the altruism of the American people—much as the publicity about relief assistance in Southeast Asia did after the tsunami. ***MR***

NOTES

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