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14. ABSTRACT The United States Navy plays a pivotal role in the ongoing Global On Terror in the provision of Maritime Domain Awareness through the conduct of Maritime Security Operations (MSOs). These operations range from permissive visitations to possible opposed boardings. It is imperative that operational planners ensure that adequate Health Service Support (HSS) is available not only for U.S. and Coalition personnel, but also for potential detainees. The range of HSS that may be required varies from routine health and sanitation visits to afloat trauma care in the event of wounding or serious injury. A review of recent available lessons learned indicates while ccurrent guidance and oversight is very effective, there is opportunity for process improvement. This paper examines current concerns regarding the provision of HSS for detainees in MSOs. The author concludes that greater focus on training of deployed medical personnel, especially in regards to ethical issues, can be of benefit to operational commanders in reducing confusion about the applicability of the Geneva Convention. The author recommends that standing rules of care include address the provision of HSS for detainees in MSOs with as much detail as possible. Specific areas for focus include the provision of aeromedical evacuation to higher levels of care when necessary and promulgation of a code of conduct for medical personnel involved with detainees.

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HEALTH SERVICE SUPPORT FOR DETAINEES IN MARITIME SECURITY OPERATIONS: WHAT IS REQUIRED AND WHAT IS RIGHT?

by

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A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

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The paper is a better product because of their expert input. I take responsibility, however, for any factual errors that may appear due to my misunderstanding or misinterpretation of any information they may have shared with me. *BRM*

Abstract

The United States Navy plays a pivotal role in the ongoing Global War On Terror (GWOT) in the provision of Maritime Domain Awareness through the conduct of Maritime Security Operations (MSOs) that control the flow of possible contraband and terrorists across the seas. These operations range from permissive visitations to possible opposed boardings. It is imperative that operational planners ensure that adequate Health Service Support (HSS) is available not only for U.S. and Coalition personnel, but also for potential detainees. The range of HSS may vary from oversight of routine health and sanitation visits to the provision of afloat trauma care in the event of wounding or serious injury. To ensure uniform rules of care are provided, senior Navy Medical Department personnel at the Naval Force Commander level of command provide guidance and oversight for operational commanders and the medical departments of units deployed to their areas of responsibility. Recent sentinel events referable to the provision of HSS for detainees in U.S. custody undermine U.S. instruments of "soft power" in the pursuit of our National Security Strategy. Recent experience in detainee HSS in the GWOT suggests that there is opportunity for process improvement. This paper examines current concerns regarding the provision of HSS for detainees in MSOs to distinguish between what is required and what may be considered to be right. The author concludes that added emphasis on aspects of HSS for detainees in operational plans, especially in regards to ethical issues, can be of benefit to providers and operational commanders in reducing confusion about the applicability of the principles of the Geneva Convention. By doing what may be considered to be right, U.S. moral authority can be preserved and serve as a force multiplier for military operations.

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Introduction

The United States Navy has a vital role to play in our nation's ongoing Global War On Terror (GWOT). One of the Navy's missions in the GWOT is contributing to Maritime Domain Awareness, defined as "the effective knowledge of all activities associated with the global maritime environment that could impact the security, safety, economy, or environment of the United States."[1] Two types of operations in pursuit of this goal are Maritime Interdiction Operations (MIOs) and Visit, Board, Search and Seizure (VBSS) operations, grouped together as Maritime Security Operations (MSOs) for this paper. These operations are "the act of interdicting suspect vessels to determine if they are transporting goods or persons prohibited by the sanctioning agency to or from a specific nation, nations, or non-state sponsored organizations" and may result in the detention of suspect vessels and their crews.[2] Such operations have long been used as tools to regulate the flow of arms, contraband, and persons of interest on the high seas and derive their authority from existing international law and domestic legal statutes. MSOs may range in scope from permissive inspections to opposed boardings with the potential for mass casualties.

The foremost concern for operational commanders in these operations is force protection for U.S. or coalition personnel who may go in harm's way, including the provision of adequate Health Service Support (HSS) for their forces. While not the chief concern, prior planning for the provision of HSS to potential detainees is also necessary. Suspect vessels and their crews that have been interdicted by U.S. forces may remain in custody for some time until a suitable disposition can be made. Regardless of their legal status, the crews of intercepted vessels are de facto detainees while they remain in U.S. custody and are entitled to humane treatment.

Recent events regarding the treatment of detainees in U.S. military custody have contributed to negative perceptions of U.S. moral authority, both domestically and internationally.[3] Additionally, there have been allegations of improper conduct on the part of armed forces medical personnel responsible for provision of HSS to detainees.[4] Such negative perceptions undermine U.S. "soft power" as an instrument of our National Security Strategy (NSS).

The moral authority that our nation possesses in the world community serves as the bedrock for our "soft power" and is derived from our nation's core values. To maintain our leadership position and moral authority in the global arena it is vital that our nation's military forces conduct their operations in such a manner as to uphold our ideals and values. This has direct relevance to the subject matter of this paper as to what may be required as legal minimums and what may be expected of U.S. forces under the principles of the Geneva Convention in the treatment of detainees. It is the author's thesis that the distinction between the two is of paramount importance in preserving our nation's base of "soft power." The question posed in the title of the paper may be answered by first reviewing current guidance in this area and then linking rhetoric to policy in our goal of striving to "champion aspirations for human dignity" as part of our NSS.[5] In this paper, the author will review recent lessons learned in this area and propose recommendations to help answer the above question.

Overview of HSS for Detainees in MSOs

Currently, MSOs are being conducted by U.S. forces around the world. Vessels of any nation are subject to interdiction in international waters under the rules of engagement of the responsible regional combatant commander. As such, a wide range of nationalities and accompanying demographics among the crewmembers of detained vessels is likely to be encountered in the course of such operations. Most detained crew members will be foreign nationals, with many originating from third world countries. Given the range of the demographics of detained crew members, it is likely that they may have ongoing health care

issues prior to their detention. Medical conditions that require urgent referral to higher echelons of medical care beyond that of the detained vessel must be conducted within the purview of U.S. forces. Current doctrinal publications state:

> There is a humanitarian obligation concerning basic health maintenance and medicines of the diverted crew. MIO ships usually have limited organic medical support, equipment, and supplies, whereas detainees often exhibit chronic medical conditions that require extensive support and MEDEVAC [Medical Evacuation].[6]

The provision of health services in the conduct of such missions presents unique challenges to operational commanders. Such challenges begin with force protection for U.S. personnel. In addition to the possibility of violence, adversaries could exploit MSOs as a way to expose U.S. forces to asymmetric threats, including exposure to infectious diseases among the detained crew that are difficult to detect and treat. Additional challenges may include the legal status of the vessel and the crew, location of the vessels, the nature of the medical conditions encountered, medical capabilities of merchant vessels and U.S. Navy ships, aeromedical evacuation capability, and the need for coordination with other agencies and host nations. Guidance and oversight for the myriad of possible situations that may arise is provided at the operational level of command by the Naval Force (NAVFOR) Surgeon whose training and experience make him an invaluable subject matter expert.

Role of the NAVFOR Surgeon

The NAVFOR Surgeon is one of the Naval Service Component Commander's special staff. His principal role is in supervising HSS for all units under his Area Of Responsibility (AOR). In this capacity, he may be tasked with serving as the Joint Force Maritime Component Commander (JFMCC) Surgeon for major operations in support of a Joint Task Force or for advising the NAVFOR commander on matters regarding the Theater Security Cooperation Plan (TSCP). Statutory functions of HSS at the operational level of command are outlined in the Unified Joint Task Lists.[7] These functions broadly encompass the following tasks:

> To provide health service support in the operational area to include, but is not limited to: health services resources; preventive and curative health measures; patient evacuation; return to duty determination; blood management, medical logistics; combat stress control, medical, dental, veterinary, ancillary services, optometry, medical food supply, and medical intelligence services.[8]

As many Naval units may be involved in the performance of MSOs at any one time in the AOR, the NAVFOR/JFMCC Surgeon monitors the HSS aspects of these operations to ensure conformity with existing doctrine. Situations may be encountered that are not addressed by doctrine and it is imperative that the NAVFOR/JFMCC Surgeon use the principles of operational art in providing guidance when needed.[9] As operational art and doctrine are derived from experience, an analysis of available lessons learned from provision of HSS for detainees in the GWOT will help to place this role in context and provide the basis for recommendations for process improvement.

Sources of Recent Lessons Learned

Recent lessons learned pertaining to detainee HSS come from both land-based and maritime operations in Operation ENDURING FREEDOM (OEF) and Operation IRAQI FREEDOM (OIF). The 26th Marine Expeditionary Unit (MEU) medical detachment provided HSS to detainees at Kandahar Air Base in Afghanistan during OEF from December 2001 to January 2002. The detachment leader identified seven areas as critical lessons learned in his after action report. These areas dealt with medical evacuation, ethics, utilization use of detainee medical providers, allocation of medical resources for detainees, prediction of the number of detainees requiring HSS and the nature of the medical problems, body cavity searches, and security concerns.[10]

The U.S. Army's Judge Advocate General's Legal Center and School has published lessons learned regarding confusion about eligibility for patient care and the need to devise rules of care for dealing with non-coalition personnel for both OEF and OIF.[11] [12] Input from the command Staff Judge Advocate was vital in both operations in addressing legal concerns and in devising guidance for the commander.

In serving as the Combined Task Force 51 Surgeon in OIF, the author will inject his experience in dealing with land-based units, the Casualty Receiving and Treatment Ships (CRTS) of the Amphibious Task Force, the U.S. Naval Hospital Ship, and coalition partners, in coordinating HSS for Enemy Prisoners Of War (EPOWs) afloat.[13]

Additionally, requests for information were sent to current senior Naval Medicine Operational leaders. Feedback from them indicates that the subject matter of this paper is very pertinent to contemporary operations. Collaboration and knowledge sharing via distributive informatics between NAVFOR Surgeons, Numbered Fleet Surgeons, and deployed units is ongoing to augment current guidance and ensure that uniform and interoperable procedures are being coordinated with other services and agencies in all theaters.[14]

Given the available database, the author will proceed to an analysis of the key functional areas that may benefit from recommendations for further revision.

Analysis of Key Functional Areas

Defining the potential detainee Population At Risk (PAR) is difficult given the wide range of situations that may be encountered. Confusion may exist as to eligibility for care and what level of service may need to be provided for detainees or other persons encountered in the course of operations. This confusion can be exacerbated by the legal status of individual detainees. In the Coalition Force Land Component Commander (CFLCC) experience, there were initially no good metrics to guide preparations for possible detainee HSS. Eventually, a patient care matrix was devised to help identify patient eligibility.[15] Feedback from recently deployed Expeditionary Strike Groups (ESGs) indicates that while it is unlikely that large numbers of detainees will be encountered or that sophisticated levels of HSS are routinely required, contingency plans exist for small numbers of potential detainees.[16]

While humanitarian concerns are important, doctrine and prudence dictate that reasonable safeguards to protect U.S. and coalition forces involved in MSOs take precedence

over provision of HSS to detainees. Conversely, force protection considerations cannot be used as justification for failing to make adequate preparations for dealing with sick, injured or wounded detainees to the extent allowable by circumstances. Conditions may prevail that make it difficult to fully reconcile these two potentially conflicting concerns.[17]

The scope of care available afloat varies with the platform involved. Joint doctrine delineates HSS Levels of Care (LOC) that represent five phases of treatment starting with first responders (LOC 1), continuing through forward resuscitative surgery (LOC 2) and theater hospitalization (LOC 3), proceeding to en route care (LOC 4), and terminating with sophisticated medical care at tertiary referral Medical Treatment Facilities (MTFs) located within the Continental United States. The majority of Navy ships are resourced for provision of basic HSS at LOC 1. Larger platforms, such as aircraft carriers and amphibious assault ships, are resourced to provide the capability for forward resuscitative surgical care at LOC 2. LOC 3 HSS is not routinely provided for peacetime operations and requires a Request For Forces (RFF) to augment contingency operations.

While the level of health of active duty personnel is generally above that of the general population and readily supported by LOC 1 HSS capability, recent studies have shown that the state of health of the average merchant mariner, even from developed countries, is below that of the population at large.[18] This difference is even more pronounced for civilian mariners from underdeveloped parts of the world.[19] Medical personnel involved in MSOs should be prepared for a wide range of possible situations and should delineate the scope of care that can reasonably be provided at their LOC. Recognition of their limits serves not only to delineate the scope of care that may be provided for possible detainees in MSOs, but also to define thresholds for medical evacuation or anticipate the need to augment existing organic medical capability.

When prior intelligence indicates the possibility of operations where trauma is likely, a RFF to augment LOC 1 HSS may be warranted. New systems and procedures for provision

of higher levels of care aboard non-conventional platforms are currently under development and available for employment in some theaters.[20] A prototype set of equipment and supplies called the Shipboard Surgical System (SSS) has been fielded by the Commander, U.S. Pacific Fleet (COMPACFLT).[21] This equipment set is designed to provide forward-deployed resuscitative and surgical care to a small number of patients for a defined set of clinical circumstances in austere environments. This set is similar to the Forward Resuscitatve Surgical System used in OIF by the "Devil Docs", though smaller and more limited.[22] Initial testing and evaluation indicates that utilization of such a system can provide a surgical and stabilization capability in selected circumstances. While not appropriate for all routine MSOs, the employment of such a set and the personnel that are trained to use it, usually sourced from the Navy's Fleet Surgical Teams (FSTs), may offer the NAVFOR Surgeon the ability to augment the existing capabilities of a wide range of deployed platforms. This may be of benefit not only in the provision of HSS for U.S. personnel, but also in selected situations where the apprehension of High Value Targets may be involved. As the personnel of the FST need to be transported to deployed units, issues of sufficient lead time for employment are problematic and are under consideration. If the Concept of Operations (CONOPS) is validated, the capability of the SSS may contribute greatly to expanding the scope of care to non-traditional platforms.

Another issue is that of the performance of body cavity searches on ingress processing of detainees. This is done not looking for clinical pathology, but for weapons or contraband. While medical personnel are commonly tasked with this duty, it may be delegated to security personnel after appropriate training and with suitable oversight.[23] Given the recent negative reports about the violation of cultural sensitivities of detainees, such procedures have been changed by a recent Department of Defense (DOD) memorandum. Body cavity searches can now be done for security reasons only when a reasonable suspicion

of possible contraband exists and they must be approved by the first Flag or General Officer in the chain of command.[24]

Adequate documentation of any medical care provided is essential as such documentation not only provides a chronological record of the state of health of individuals, but may also serve as the basis for medico-legal investigations. This is all the more imperative in provision of HSS for detainees. A sufficiently thorough history and examination must be conducted at the time of incarceration to document the state of health of the detainee to serve as a basis for comparison for later events, especially if allegations of mistreatment may arise. Such documentation may commonly include the use of photographs to serve as a visual record.[25]

Privacy issues for detainee HSS need to be addressed. Generally, medical information is considered to be privileged and is released only with the consent of the individual or to selected authorities on a "need-to-know" basis. Recent press coverage has criticized the use of medical documents as improper.[26] Medical providers and operational commanders should have clear guidelines in place to safeguard the medical records of detainees and prevent improper release or use. A good faith attempt should be made to inform the individual of the release of confidential information. Additionally, information regarding the status of individual detainees may need to be made available to International Organizations (IOs) such as the International Committee of the Red Cross (ICRC) or the country of origin of the individual involved.

The use of retained medical personnel to perform clinical care for detainees is permitted under the Geneva Convention. In extensive and prolonged land-based operations involving large numbers of EPOWs or detainees, this may prove to be of benefit under some circumstances in providing additional staff. However, in MSOs with smaller numbers of potential detainees, the wide variance in training and experience in the detained providers likely to be encountered makes this inadvisable in general.[27] An exception may be extremis

situations such as mass casualty scenarios where identification of such individuals ahead of time may allow them to assist in providing triage and basis emergency response management.

Most operational units are resourced primarily to provide medical care for organic crews and embarked staff and have limited resources to provide care for large numbers of detainees. Also, one detainee with a serous illness may consume a large amount of supplies in a short period of time.[28] Every attempt should be made to provide an equitable level of care to detainees consistent with the principles of the Geneva Convention, even though the legal status of the individual does not grant them such rights. Allocation of resources for detainees based on medical necessity must not degrade the medical capabilities of the medical department to such an extent that mission integrity is jeopardized.

It is expected that the majority of care rendered to detainees can be provided either aboard their vessel by organic providers, by visiting U.S. providers, or during temporary evacuation to U.S. vessels for more extensive urgent care. While unlikely, the need for temporary hospitalization of detainees in the sick bay of a U.S. vessel may be necessary. All Navy ships have procedures for handling EPOWs or detainees in such a situation. If the condition of the detainee warrants urgent referral to a higher level of care, then the same rules of care that apply to U.S. personnel should be used, to the extent possible given the location of the vessel, force protection concerns, medical evacuation capability, and ability to transfer the individual to an accepting MTF. This can prove to be difficult as adjudged by feedback from deployed units.[29] The capability to effect such evacuation will most likely prove to involve joint, interagency, multinational, and other groups such as IOs or Non-Governmental Organizations (NGOs). Numerous factors such as legal status of the individual, en route care, hand-off, security, international law, funding, and other logistics are likely to be involved.[30] While planning cannot encompass provision for all contingencies, pre-existing mechanisms for coordinating such missions can be helpful.

Planning for medical evacuation should include provisions for the repatriation of the remains of detainees that may expire while in U.S. custody. Sufficient documentation as to the treatment provided and cause of death should be available from the units involved to allay any concerns as the appropriateness of the care provided. When adjudged to be useful and on the approval of higher authority, remains of decedent detainees may be evacuated to the Armed Forces Institute of Pathology for a definitive post-mortem examination. This has been done recently in OEF and has served to counter criticism of U.S. intent and treatment.[31]

Ethical Considerations

DOD has promulgated policy entitled "Program for Enemy Prisoners of War (EPOW) and Other Detainees" that provides guidance for provision of services to persons incarcerated by the military.[32] While the rules regarding EPOWs are clear, the legal status of detainees, variably called EPOWs, illegal combatants, under-privileged detainees, or other categorizations, can be confusing. Such confusion blurs the lines of distinction in HSS between the provision of essential services required by existing statutes and the provision of clinical services that are in accordance with the principles of the Geneva Conventions, even when the articles may not be legally applicable. A distinction between what is the minimum required by legal codes and what is considered right based on humanitarian and ethical concerns regarding medical care may seem trivial or overly concerned for the welfare of potential terrorists. The author would argue that such distinctions are paramount in upholding American moral authority. As a nation, we expect that our service members who fall into enemy hands will receive humane treatment consistent with the principles of the Geneva Convention. The shocking accounts of abuse and lack of adequate medical care for U.S. servicemen held captive during the Vietnam War are sobering examples of the moral bankruptcy that ensues when such principles are disregarded.[33] The conduct of our armed forces in both war and peace should clearly serve as an example to others.[34] The President

has articulated the need to provide humane treatment to individuals who are detained by the armed forces:

> I hereby reaffirm the order previously issued by the Secretary of Defense to the United States Armed Forces requiring that the detainees be treated humanely and, to the extent appropriate and consistent with military necessity, in a manner consistent with the principles of Geneva.[35]

Military medical personnel undergo indoctrination in the principles of biomedical ethics during initial clinical training. Additional training regarding the Geneva Convention and the provision of HSS to EPOWS under the Law of Armed Conflict is conducted in the Combat Casualty Care Course at the Joint Defense Medical Readiness Training Institute in San Antonio, Texas. This training is usually done early in the career of medical department personnel. Refresher training is normally performed in conjunction with deployments on a "just in time" basis.[36]

Recommendations

Based on the analysis of the areas addressed in the previous section, the author proposes the following recommendations be considered for implementation at the NAVFOR Surgeon level of HSS oversight.

The Annex Q (Health Services) to Operational Plans (OPLANs) and their equivalent should contain a separate Appendix dealing specifically with HSS relating to EPOWs and detainees. The Appendix 1 to the training sample cited herein is an excellent example to follow.[37] As a part of this appendix, a Tab with a patient eligibility matrix should be included similar to that of the CFLCC matrix referenced above. This matrix would outline eligibility for services and the scope of care that is to be provided for EPOWs and detainees based on the organic Level of Care capability of individual platform medical departments.

Clear guidelines should be spelled out for common procedures to be employed and allocation of medical resources for detainees when supplies may be constrained. A Rules of Care matrix should be included as a separate Tab to the EPOW/Detainee Appendix to the

HSS Annex, similar to that used in OIF.[38] This Tab would specifically address issues related to detainees, including provision of food and water, medical participation in interrogations, informed consent, medical documentation, reporting requirements, suspected abuse, and referral to higher echelons of care.

Also included should be guidelines for allocation of medical resources for detainee health care that balances both the principles of the Geneva Convention and the necessity to preserve mission integrity for U.S. military forces. The purpose of such guidelines would be ensure that medical resources for detainees are not withheld unnecessarily. A section of this Tab should cover documentation for any instance in which inadequate medical resources were felt to exist to properly provide HSS for detainees and require notification of higher command echelons.

When validated and approved by the Bureau of Medicine and Surgery (BUMED), the capabilities of the SSS and the CONOPs to employ it in MSOs should be incorporated into present mechanisms for augmenting deployed units as quickly as possible. The addition of the ability to field forward-deployed surgical capability aboard non-traditional afloat platforms will markedly enhance HSS for all maritime operations.

Whenever feasible, the NAVFOR Surgeon should coordinate with joint, interagency, and multinational authorities to implement pre-existing procedures for medical evacuation of detainees to definitive care at land-based MTFs. As this may involve host nation support using non-U.S. medical facilities, such procedures should at a minimum inform the appropriate U.S. ambassadors, host nations involved, and ICRC, consistent with mission requirements. The possibility of partnering with the health assurance firm International SOS, as is done under the Tricare Global Remote Overseas program for deployed active duty service members, to assist in such evacuations should be studied. Security concerns and funding mechanisms will be difficult issues to resolve, but if feasible, such an arrangement would simplify the logistical problems encountered.

Even though they may be aware of the principles of the Geneva Convention, U.S. military medical personnel may have moral reservations about providing care to "bad guys."[39] Medical department personnel in the armed forces have an implicit duality in their military obligations to their chain of commands and their ethical obligations as providers to serve as advocates for patients under their care to the maximal extent possible. There is a body of medical literature that discusses the potential conflicts of providing medical care to detained persons.[40] Some professional medical societies have a code of conduct for their members regarding their obligations to provide medical care for prisoners.[41] Senior operational Naval Medical leaders are aware of these issues and strive to ensure that medical care for detainees is conducted professionally and in accordance with accepted international standards.[42] Providers need to have a clear sense of how best to de-conflict their emotions in respect to their duties. This is especially important in areas such as participating in interrogations of detainees and their responsibility to report suspected abuse in a professional and timely manner, even when such actions may result in possible repercussions to their careers.

Principles unique to the provision of HSS for detainees in military operations should be drafted into a code of conduct based on those of recognized medical bodies dealing with health care for prisoners.[43] As civilian guidelines are not directly applicable in all circumstances, they should be reviewed with legal authorities at the U.S. Navy Bureau of Medicine and Surgery (BUMED), the combatant Commanders, and coordinated with other interagency services to ensure consistency. When finalized, they should also be included as a tab to the EPOW/Detainee Appendix to Annex Q. Training in the code of conduct for HSS for EPOWs and detainees should be conducted periodically for all Naval Medical Department personnel and incorporate evolving issues experienced in the conduct of the GWOT. Senior personnel should serve as mentors for junior personnel in addressing any moral reservations they may have in this area to avoid the phenomenon of the "strategic

corporal" becoming involved in adverse events that may reflect discredit upon the United States.

Conclusion

American military forces continue to face daunting challenges in providing for the security of our nation in an increasingly complex and multi-polar world. Current doctrine and policies provide sound guidance to our forces in the prosecution of their missions, but there are opportunities to make this guidance even better. Wider implementation and standardization of procedures for the provision of HSS to detainees will serve to enhance the professionalism of our medical department personnel. Increased awareness on the part of military medical personnel regarding detainee HSS will in turn assist operational commanders in effectively and efficiently conducting their missions around the globe and demonstrate both U.S. military capability and moral authority.

While standardized procedures provide formal guidance for our actions, in the end it is the core values of our nation, services, and citizens that serve as the ultimate guide in doing not only what is required, but what may be considered to be right. It is easy to do good things for good people, but the ability to do good things for bad people, not because we have to, but because it is the moral thing to do, is an inherent and enduring trait of the American way of life. Our Commander in Chief has stated*:*

> Our values as a nation, values that we share with many nations in the world, call for us to treat detainees humanely, including those who are not legally entitled to such treatment.[44]

In conclusion, the author would exhort his operational medical colleagues to continue to "walk the talk" and do not just what is required for detainees, but what is right.

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