

AIR COMMAND AND STAFF COLLEGE

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**DETAINEE HEALTHCARE IN THEATER HOSPITALS: ARE AIR
FORCE MEDICS PREPARED FOR THE CHALLENGE?**

by

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Preface

In 2004, I had the opportunity to take part in US Air Force Medical Service (AFMS) history. In late August, 170 Air Force medics from across the AFMS deployed to Balad Iraq to provide full spectrum care to the troops serving in the area of responsibility (AOR). Prior to our arrival in Iraq, the US Army 31st Combat Support Hospital had the reigns and delivered, what is arguably, some of the finest medical care our troops have seen in modern warfare. The First Air Force Theater Hospital (AFTH) had a daunting task with large shoes to fill, but the group was eager, capable, and ready to execute the mission. Not since the Vietnam War had so many Air Force medics deployed en masse to provide combat medical care in a field hospital setting.

As part of the first iteration of AFMS medics to deploy there were many lessons learned and many still to be learned. My direct observations as the AFTH Nursing Supervisor validated the staff had all the clinical tools necessary for mission success. However, there were some mission essential tasks that we needed prior to the deployment, specifically detainee healthcare operations. Through recent interviews and research, it appears that since 2004, predeployment training requirements have improved but there is still much to be done. My research looks at one concerning aspect of the deployment---are medics really prepared to care for detainees in the AFTH environment?

I would like to thank everyone that assisted me in this research. The vast amount of information I received from the AFTHs, Army SG's, Military Police (508th MPs), and the US Air Force Culture and Language Center staff was immeasurable. The GITMO staff and the Detainee Operations Center at Fort Lewis and Camp Shelby were quite helpful with providing curriculum and training templates. I also want to thank my advisor Maj John Mansuy for providing direction, clarity, and support during this research process.

Abstract

Since 2004, Air Force medics have been deployed to the Air Force Theater Hospitals. Often there is a significant detainee population requiring various levels of medical care. Most medics deploying to AFTHs have minimal realistic training on force protection, cultural competence, and ethical considerations before departing to the area of responsibility. Although, there are numerous potential training platforms in the Air Force to conduct detainee operations training, the overall quantity of training is limited. This research investigates how the AFMS can better prepare medics for detainee care in the AFTHs?

This paper will explore the various essential considerations that medical personnel should have prior to, and upon arrival in the AOR. A review of current joint training platforms and the potential for new Air Force training methodologies will be discussed. Given the nature of war and its hostile environment, a medic with a full toolkit of cultural, ethical, and force protection training will be able to effectively care for detainees. Additional competency training in detainee operations, improved AF training platforms, and increased access to joint service training opportunities are methodologies that will bolster competency and provide AF medical personnel with invaluable expeditionary skills.

Introduction

Taking of prisoners in war is as old as warfare itself. The first laws of war can be traced back to Hammurabi the King of Babylon.¹ Wars of all proportions produce battlefield casualties and the way armies treat these casualties varies with history. In the earliest days, wounded adversaries saw very little hope of survival. Wounded soldiers were tortured, made slaves, or most often killed. The side holding the prisoner of war cared little about their adversaries' cultural or social beliefs.²

According to Andre Corvisier, "Vanquished troops who were wounded or surrounded were likely to be massacred on the battlefield."³ Corvisier also points out "as nations came under a central power the status of prisoners changed dramatically; they now belonged to the state and not to the warrior who had captured them."⁴ Rulers of the conquered armies kept their prisoners alive for propaganda purposes and then executed or subjugated them into slavery.⁵

The way the US processes and cares for prisoners of war in the modern era is due largely in part to Henri Dunant. Dunant, a Swiss born businessman and social activist, was enraged by number of wounded soldiers he saw on the battlefield of Solferino and Castiglione in Northern Italy in 1859.⁶ During the battles for Italian unification, Dunant helped treat the wounded on the battlefield and then returned to Switzerland. In 1862 he founded the International Committee of the Red Cross (ICRC). Two years later Dunant helped establish the first iterations of the Geneva Convention.⁷ By the turn of the century, the concept of just war was emerging on a global perspective. The Hague Conventions followed and the new laws governing the limitations of suffering in war were born.⁸

Purpose of Research

Given the limited US Air Force training platforms available to prepare medics for

detainee care, this research investigates how the Air Force can better prepare all medics for detainee care in AFTHs. Air Force medics continue to deploy to Air Force Theater Hospitals (AFTH) where a substantial detainee populations exists requiring various levels of medical care. Most medics deploying to AFTHs have minimal realistic training on force protection, cultural competence, and ethical considerations.

Standardized training modules, realistic hands on predeployment programs, and joint training platforms focusing on force protection, cultural, and ethical issues will give medics a toolkit rich in knowledge that prepares them for patient care in this volatile environment. Although there have been no substantiated attacks on medical personnel caring for detainees in the AFTHs, the opportunity for violence and harm to medical personnel is great.⁹ Proper training prior to deployment and in theater are essential to ensuring the safety of all medics.

Background

News reports from Abu Ghraib and Guantanamo inundated the world media with respect to detainee rights and humane care requirements for this select population. Since inception, Abu Ghraib, Guantanamo (GITMO), Camp Bucca¹⁰, and Bagram have been identified as a detainee center or Theater Internment Facility (TIF). The primary function of the TIF is to inter, interrogate, and prosecute suspected terrorists.¹¹ The majority of the staff, to include medical personnel, deployed to work at TIFs are required to attend several months of intensive training prior to working in these facilities.¹² Air Force medics continue to deploy to AFTHs where similar detainee population exists; however, training for these medics is minimal compared to the training a medic receives prior to an assignment at a dedicated TIF.

A recent U. S Central Command Air Force (USCENTAF) Surgeon General policy states “all medical team members involved in the management and delivery of health care, including

administrative personnel, must complete Medical Ethics and Detainee Operations training and provide documentation to their unit deployment manager (UDM) prior to deployment to the area of responsibility.”¹³ Deploying members must log on to the Military Health System Training Portal (MHS Learn), obtain an account, complete the Medical Ethics and Detainee Operations eStudy course, print completion certificate, and then hand carry the record to the deployed location.¹⁴

In a hostile and potentially unpredictable environment, such as a detention/internment facility, the need for a more thorough and structured hands on programs is necessary.¹⁵ Scenario based training programs should be administered separately or in conjunction with existing computer based training (CBT) programs¹⁶ such as the Advanced Distributive Learning Service (ADLS).¹⁷ The Detainee Operations Center program at Fort Lewis (Washington), Fort McCoy (Wisconsin), and Camp Shelby (Mississippi) are just a few of the benchmark programs the Air Force could use as a template for training medics in non-traditional detainee environments.”¹⁸

Clarification of Key Terms/Concepts

Medical personnel caring for wounded adversaries need a thorough understanding of enemy combatant status. The Geneva Convention and International Law requires US personnel to humanely care for all wounded despite their categorization in war.¹⁹ Therefore, medics need a basic understanding of the types of prisoner categories that exist doctrinally.²⁰ A brief description of the key prisoner categories as they pertain to the current Global War on Terrorism (GWOT) will be reviewed. For the purpose of this paper, and to limit complexity, the term detainee is used since this has been the pervasive terminology throughout Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The term detainee has complicated and ambiguous definitions. The use of *detainee* has evolved since 2002, primarily because of the nature of the

current war and the diverse enemy combatants (EC) that the US is engaged with. The use of *detainee* and the associated privileges that accompany the term is based upon the 2002 Bush administration memorandum.²¹

The Department of Defense considers a detainee “any person captured, detained, held, or under the control of the DOD personnel (military, civilian, or contractor employee). It is not applicable to persons being held for law enforcement purposes, except where the United States is the occupying power.”²² Detainees are associated with the full gamut of the current war and are considered civilians, so domestic law plays an important part in governing how they are to be processed. Enemy combatants, although they do not legally fall under the rules of the Geneva Convention, are still entitled to be treated humanely consistent with the principles of Geneva Convention.²³ The premise is that ECs be afforded privileges not rights during this GWOT.²⁴

Enemy combatants are further stratified by JP 3-63 as the following:

- (1) Low Level Enemy Combatant (LLEC) who are detainees that are not a threat beyond the immediate battle space or that do not have high operational or strategic intelligence or law enforcement value.
- (2) High Value Detainee (HVD), which is a detainee who possesses extensive and/or high level information of value to operational commanders, strategic intelligence or law enforcement agencies and organizations.
- (3) Criminal Detainee, which is person, detained because he/she is suspected of having committed a crime against local nationals or their property or a crime not against US or coalition forces. However crimes against humanity or atrocities would exclude them.
- (4) High Value Criminal (HVC) a detainee who meets the criteria of a HVD and is reasonably suspected of having committed crimes against humanity or committed atrocities, a breach of humanitarian law that is an inhumane act committed against any person.
- (5) Security Detainee. A civilian interned during a conflict or occupation for his or her own protection.²⁵

It should be understood, that handling detainees differently based on categorization, does not equate to different standards of medical treatment. It is also important to note that doctrine may vary from country to country, but most of the signatories of the Geneva Convention have

similar approaches in the management of detainees. It is Department of Defense (DOD) policy that all persons detained by the Armed Forces of the U.S during the course of military operations shall be treated humanely from the moment they fall into the hands of US forces until their release.²⁶ The “inhumane treatment of detainees is prohibited by the Uniform Code of Military Justice (UCMJ), domestic and international law, and DOD policy.”²⁷

Finally, Enemy Prisoners of War (EPW) according to U.S Joint Doctrine is “a detained person as prescribed in Articles IV and V of the Geneva Convention.”²⁸ An EPW is typically “under combat orders of his or her government when they are captured by the armed forces of the enemy. As such, he or she is entitled to the combatant’s privilege of immunity from the municipal law of the capturing state for warlike acts which do not amount to breaches of the law of armed conflict.”²⁹ To date, US policy with respect to rights, is shifting minutely to meet the terms related to EPWs and detainees involved in GWOT.³⁰

Research Limitations

A substantial amount of data is available on both detainee operations and basic medical care of detainees. There is however, limited data available looking specifically at the subject of detainee care in theater/field hospitals with respect to all-inclusive training programs. The majority of information reviewed speaks to medical personnel being assigned primarily to TIFs. Air Force medics within the past few years have been providing their medical care skill sets at locations such as Camp Bucca and are participating in the Army predeployment training programs. Because of this, one can speculate Air Force medics who deploy to TIFs have significantly more knowledge prior to their deployment and are better prepared for the challenges of detainee operations. The detainee operations program points of contact (POC) were a challenge as well. Army units rotate responsibilities of these taskings so finding the right

point of contact took some effort. Those POCs contacted did not always have the same data or access to information as their predecessors. In one situation a former course POC relayed that statistical data for AF personnel attending Army detainee operations programs was available. However, after consulting with the current operations POC, no data of AF personnel was on hand.

Law of Armed Conflict (LOAC)

Various laws and treaties govern conduct in war and legally bind the US to its actions during a war. The Hague and Geneva Conventions, Law of Armed Conflict, and International Law guide participating nation states during the course of a war. The law of war applies to “all cases of declared war or any other armed conflicts that arise between nations, even if the state of war is not recognized by one of them.”³¹ These principles are bound in the common articles of the Geneva Conventions. The law of war is also defined as international law and its primary concept is to regulate the conduct of armed hostilities. It is often termed the Law of Armed Conflict or LOAC.”³²

Air Force medical personnel are constantly reminded of these laws every 20 months with training in Geneva Conventions/LOAC. Despite this training, not all medics fully understand the detailed information with respect to POW and detainee protections. It is up to AF leaders to ensure their personnel are fully aware of these laws. All leaders must continue to reiterate the purpose of LOAC training; that it exists to limit the damages and effect of combat, protects combatants and non-combatants from undue pain and suffering, and advocates for combatant and non-combatants basic human rights. Furthermore, LOAC covenants attempt to prevent an escalation in the war to hope for a better peace.³³

Hague and Geneva Conventions

The Hague Conventions focus on the methodology of warfare, essentially, how military members conduct themselves during a war. Also it is ultimately the framework for the treatment of captured or retained personnel.³⁴ Chapter II, article 4 outlines the humane treatment of prisoners of war.³⁵ Chapter III, article 21 addresses the obligations to belligerents with respect to the sick and wounded.³⁶ The Hague Conventions also discuss the establishment of safe zones to protect the sick and wounded civilians.

The Geneva Conventions is ultimately concerned for the victims of war or armed conflict. The Geneva Conventions consist of four separate international treaties, signed in 1949 with additional protocols ratified in 1977.³⁷ The First of the Geneva Conventions (GC I) is for the amelioration of the conditions of wounded and sick in armed forces in the field. The second Geneva Convention (GC II) is for the amelioration of the conditions of wounded, sick and shipwrecked members of the armed forces at sea. The Third Geneva Convention (GC III) is relative to the treatment of PW. The Fourth Geneva Convention (GC IV) is relative to the protection of civilian persons in time of war.³⁸

The 1977 protocols of the Conventions were established to limit the use of violence and protect civilians by strengthening the rules that govern the conduct of hostilities. The two additional protocols are to give greater protection to victims of both international and internal armed struggles such as civil wars and protections to civilian medical workers involved in regional conflicts.³⁹ Military medical personnel face immense challenges in a combat zone and must always remember *primum non nocere* or “First, do no harm.”

Health care personnel have a duty in all matters affecting the physical and mental health of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees and to ensure that no individual in the custody or under the physical control of the Department of

Defense, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment, in accordance with and as defined in U.S.⁴⁰

On numerous occasions between August 2004 and February 2005, the AFTH in Balad was 50 percent filled with detainees. Much of the nursing staff was at odds with current environment and commented on the obvious, “We are taking care of more detainees than our own soldiers.”⁴¹ Unfortunately, this is the reality of GWOT and why it is so important that the predeployment training in LOAC is critical. The GWOT has made the signatories of these aforementioned treaties reevaluate the way they interpret the rules of war.

The insurgency in Iraq and Afghanistan, and the subsequent capturing of these illegal combatants/detainees, has made the US rethink its approach on handling detainees from a legal perspective as well. The important key point with this review of law of warfare is that the treaties and conventions are numerous and continued review of the Geneva Conventions and LOAC is pertinent to ensuring medics act accordingly in a war zone.

Available Detainee Operations Training Platforms

The preponderance of comprehensive detainee operations training in the military is associated with Army training platforms. Although all branches of service engage in ethical, cultural, and force protection training, the degree and amount of relevant detainee operations training varies from service to service. DOD Directive 2311.01E mandates the DOD Law of War Program across the services, but again, this directive focuses on how service members should conduct themselves during times of war towards the enemy.⁴² LOAC, Hague, and Geneva Convention articles focus primarily on prevention of violations against enemy combatants. The question raised is what type of additional programs or information should be available to medical personnel prior to a deployment that protects the medic?

As mentioned previously an Air Force medic typically receives a self-directed,

compulsory, and brief overview on LOAC and Ethical Care of the Detainee, but is it enough to prepare and protect them? What training programs or additional courses should be taught to better prepared medics for detainee care in the AFTH setting? Where else can this training be sought? In order to have a better understanding of the various detainee operations programs we must examine what the Army delivers to its Soldiers juxtaposed to the current Air Force programs.

Army Training Perspective

As the lead agent in detainee operations, Army medics are given basic classes on the Geneva Convention, LOAC, ethics, principles of combat care, and technical elements of medical care in a TIF. Several Army Military Police (MP) officers with expertise in detainee operations and training were interviewed by phone and/or through email correspondence. Their collective input was that “classes are typically taught by organic leaders, medical personnel, and guest speakers for subjects such as cultural sensitivity, ethical care, and laws of war.”⁴³

The MPs also indicated that the regulations used to generate these classes comes from the Geneva Convention article III and IV, ST 4.02-46 (Medical Support to Detainee Operations), AR 190-8 which provides “policy, procedures, and responsibilities for the administration, treatment, employment, and compensation of enemy prisoners of war (EPW) and other types of detainees in the custody of U.S. Armed Forces”⁴⁴, AR 40-66 (medical records establishment), FM 3-19.40 (internment/resettlement operations), DODD 2310.08E (Medical Program Support for Detainee Operations), and DODD 3115.09 (DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning). These documents are the fundamental building blocks that will prepare soldiers and Army medics to be responsible for the full spectrum of detainee care.⁴⁵

It is also a requirement for all Army medics deploying in support of detainee operations to receive online and scenario based training on the following subjects: intro to detainee ops, stress management procedures, detecting detainee abuse, cultural sensitivity, safety techniques (force protection), working with detainees and EPWs.⁴⁶ In addition to these classes, it is also mandated that all medical personnel review the CD/website module on “Medical Ethics and Detainee Healthcare” on MSH Learn. The Detainee Operations course at Fort Lewis and other locations is a premier training platform for realistic detainee operations. The course is typically 45 days long, however medics only attend nine days, and covers many of the subjects mentioned previously (Figure 1).

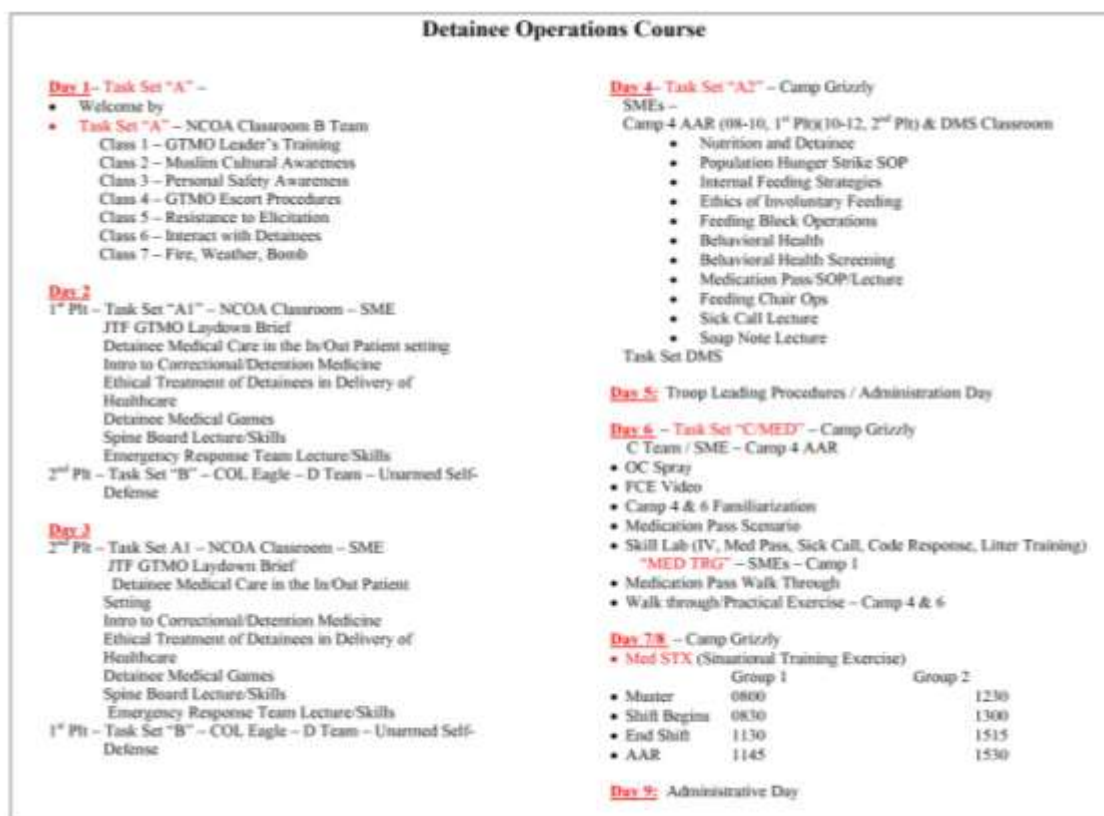


Figure 1. Detainee Operations Course (Fort Lewis)

Camp Cassion/Grizzly as it is referred to, provides Army, Navy, and Air Force units, training platforms that will prepare them for deployment in support of detainee ops.⁴⁷ Every

service member tasked with guarding detainees in Defense Department custody goes through the Fort Lewis training, said Lt. Col. [sic] Warren Perry, commander of the Second Training Support Battalion.⁴⁸ Camp Caisson/Grizzly offers a full mock-up TIF to include detainee actors. The abbreviated course for medics provides a realistic and hands on approach to the principles and techniques learned.⁴⁹ The medical portion of the training has been open to Air Force personnel since 2003, however, only those medics going to a TIF have the benefit of this training. The culminating event to test all the principles learned over the eight days is a situational training exercise (STX). This includes the use of a mock-up of a Forward Operating Base (FOB) and a TIF.⁵⁰

Air Force Training Perspective

According to Lt Col Steve Foss, Deputy Commander for the 602nd Training Group, “The Air Force A-25 class is the standard green to blue combat skills training course, otherwise known as the U.S Army Detainee Operations Course at Fort Lewis” (and other locations).⁵¹ Airman may submit a request for training both through Forces Command (FORSCOM) and 2nd Air Force for combat skills training. Lt Col Foss contends, “This training has been invaluable with respect to realistic training for those who have attended over the past few years, however it has been primarily Security Forces and Logistical personnel in attendance.”⁵²

Some Air Force medics have attended the abbreviated course, but according to a previous training Commander at Camp Cassion, “those medics were typically going to a TIF.”⁵³ Currently, there is a limited amount of hands on detainee operations training for AFMS personnel and only a small amount of AFMS medics have attended the detainee operations course.⁵⁴ With firmly established training programs at Fort Lewis, Camp Shelby, and Fort McCoy, the AFMS should investigate sending more medics to this training on a routine basis.

Perhaps even establish a similar program for the Air Force. If Air Force medics are going to care for detainees in the AFTHs, programs such as the detainee operations course should be a priority for all medics before a deployment to an AFTH or equivalent.

Currently, the Air Force has a requirement to complete the self-directed computer based training on “Ethical Care for Detainees.”⁵⁵ There is also a requirement to complete LOAC (every 20 months), usually an online program monitored by the readiness offices.⁵⁶ LOAC and Geneva Convention training can also be completed through Medical Unit Readiness Training (MURT), Judge Advocate (JAG) office just prior to a deployment, and through unit type code (UTC) training. The drawback with CBT training is often it becomes just in time (JIT) training and only a few hours dedicated to extensive subjects. Force Protection training for medics is primarily relegated to CBT training in ADLS and weapons training every 30-36 months.

Recently, the Air Force has expanded its cultural training by adding country specific culture training on the ADLS. In 2008 the Air Force Culture and Language Center published a five year plan to improve the cultural competence of all Airmen. Cross-Cultural Competence (3C) will focus on culture general and culture specific preparation of all Airmen. 3C will be further discussed in the Cultural Competence section.

Recommended Program Improvements

The following topics are recommended areas for improvement; Force Protection, Cultural Competence, and Ethical Considerations. The subjects selected for this research was based on inputs from medics, senior medical staff, and after action reviews (AAR) in the field during the 2004-2005 AFTH deployment. Subsequent deployments after 2005 were facing similar issues with respect to preparedness of medical personnel in the care of detainees in the AFTHs. Multiple interviews with AFTH senior staff after 2005 had also indicated that these three areas of

concern were paramount for the delivery of safe and competent care to the detainee population.

Force Protection (FP)

Medical personnel that attend detainee operations courses are more prepared than those with CBT only training to handle issues of violence, safety and security, and emotional attacks directed at them by detainees. The detainee operations course provides a mix of didactic and scenario based preparation that is essential for all medics deploying to AFTHs. Air Force medics that deploy to an AFTH typically have limited detainee operations training before arrival putting them at increased risk. This additional risk is due in part to the limited training and the medic not fully understanding the complex policies and procedures with respect to security and internment.

A question that often arises is “how can a wounded detainee in the AFTH be a threat”? Medics should never underestimate that an injured detainee is capable of inflicting harm. A detainee at Guantanamo punched a female nurse who was providing care so hard that her nose was broken. The detainee then became upset because the nurses’ blood had spilled on him. The detainee then yelled in anger that the blood of an infidel was on him and demanded new cloths.⁵⁷ In another such incident, a Navy medic was severely injured during the treatment of a detainee; the medic required 16 surgeries for facial reconstruction.⁵⁸

Sources at GITMO report over 400 incidents of attacks on medics and guards annually.⁵⁹ So what preparation should medics have with respect to FP? Training for medics prior to a deployment should focus on how medical personnel can protect themselves, as well as, how to protect detainees. Clear guidelines for expected detainee behavior (Fig. 2) and comprehensive training for medical staff is paramount before detainee medical care is provided. According to DODI 2310.08E, “The Secretaries of the Military Departments and, as appropriate, Combatant

Commanders shall ensure health care personnel involved in the treatment of detainees or other detainee matters receive appropriate training on applicable policies and procedures regarding the care and treatment of detainees”.⁶⁰



Figure 2. Rules for Medical Detainees (AFTH 2004)

Ensuring that medical personnel who deliver care in an AFTH are operationally prepared is an enormous task for commanders.⁶¹ Knowing the environment and understanding the patient population is a task that should not wait for in theater right seat/left seat training. Medical staff should be educated about control of equipment and supplies before they arrive in the AOR. EMEDS training, which provides a pseudo-deployed environment to train and test field medical skills, would be an excellent platform for this training. Medical personal awareness training can keep a detainee from grabbing a stethoscope, suction tubing, or kerlex and choking the medic. Although this type of event has not occurred in the AFTH to date, the threat based on the previous GITMO examples, is some indication that detainees are certainly capable of assault.

Healthcare staff should be trained to prevent the spread of infection and how to promptly notify other AFTH personnel and guard staff of potential biological threats. A detainee with an

infectious medical condition can spread disease through saliva (spitting), close contact, or through other bodily fluids. There have been several reported cases at GITMO where detainees have thrown bodily fluids on medical and guard staff.⁶² Several of these occurrences also took place in the AFTH during 2004-2005, where urine and feces was thrown on nursing personnel during the execution of their duties. Medics also need thorough instruction on restraining and/or subduing a detainee in the event a guard is not present or unable to assist.⁶³ Recalling this author's deployment of 2004-2005, initial guidance with respect to restraining detainees was tightly controlled and required command approval. This all in the wake of the 2004 Abu Ghraib prisoner abuse incident.

Medical care in the AFTH environment is fast paced and requires focus and speed to save lives. Medics must remain alert with respect to their own physical security during the course of care. Medics that become focused solely on patient care and disregard personal security can be vulnerable to attack. Leadership coupled with relevant training platforms should focus on situational awareness training before and during the course of the deployment. Leaders at every level should perform hot washes or after action reviews (AAR) before and after a shift to discuss shortfalls and recommendations for improved security and safety.

Medical staff performing detainee health care must also understand that assisting in the security of a detainee can change their role from a non combatant to combatant, thus changing their status under the rules of the Geneva Convention.⁶⁴ If a medic is put into a situation where they become a combatant, without proper force protection and security training they will become an unnecessary casualty or war.

Detainee healthcare personnel will not provide detainee security and custody or control under any circumstances for even brief instances; nor will there ever be the perception that health care personnel provide such functions (such as they will not carry handcuffs or flex cuffs.) Medical personnel when operating within an

initial detainee collection point (IDCP), detainee holding area (DHA), or internment facility are under operational control (OPCON) of the MP unit operating the IDCP, DHA, or internment facility.⁶⁵

Force protection concerns for medics should include a daily inventory of their medical supplies with particular attention on sharp objects such as needles, scalpels, and plastic containers.

Medics should also be aware of objects used in day-to-day activities that could threaten safety, such as a pen, clipboards, plastic cups, or even a bedpan.⁶⁶ AFTH personnel involved in detainee care can also benefit from self-defense so as to have a full understanding of the use of force (UOF) if necessary.

The hair on the back of my neck goes up when [the detainees] [sic] are behind me," Rice says. "It is difficult because we want to treat everyone equally, yet we cannot get too close because they can turn on you very quickly." Some nurses have been hit, kicked, or punched by patients who were out of control.⁶⁷

Although detainee UOF is relegated to security personnel, medics may be involved in a situation where the security apparatus is overwhelmed.

Weapons or Combat Arms training every 30-36 months is part of medical readiness training for Air Force medics.⁶⁸ Weapons familiarization should be scaled up in frequency prior to a deployment and encompass close quarter combat, defensive operations, and rules of engagement relevant to detainee populations. As a nation at war, and given the high operations tempo, there has been some discussion by previous AFTH leaders that weapons qualification should be annual.⁶⁹ The carrying of firearms during patient care in the AFTH is dependent on the current command. In 2004-2005 the majority of the AFTH medical staff did not carry weapons, however key personnel did carry the M-9 pistol.

HVD are frequently brought into the AFTH and medics need to understand some security implications that accompany this type of detainee. Typically, the security force (2-3 man teams) that is guarding the detainees when they are brought in to the AFTH emergency room is

responsible for the actions of the detainees when receiving medical care. Medics should be instructed during these admissions to remove their jewelry, cover identifying scars, tattoos, birthmarks, and to remove or put tape over their nametag. Most HVD have their eyes covered with special goggles or other field expedient methods.⁷⁰ The purpose of this procedure is two-fold, maintain security and integrity of the compound/installation and ensure the safety and security of the AFTH staff as explained below:

There's nothing wrong with his eyes. The oversized bandage is there to make sure he won't be able to identify anyone after he is released. Apprehended because of his actions fighting Coalition forces in Iraq (Only captured or suspected insurgents face such restrictions), the man is a patient at the U.S. Air Force Theater Hospital at Balad Air Base. He is an emblem of the facility's policy of treating anyone, friend or foe, who arrives there needing medical help.⁷¹

Individual security is a serious matter and begins with each medic. Quite often medics are vulnerable targets because of the close proximity to detainees that is required to carry out their medical tasks.⁷² A medic or medical unit that lacks FP training and good situational awareness could succumb to a potentially catastrophic situation. It is imperative that medics receive comprehensive FP training focusing on similar subjects as taught in the Detainee Operations course. Personal safety awareness, escort procedures, resistance to elicitation, and interacting with detainees are just a few of the subjects that AF medics can benefit from.

Cultural Competence

LOAC and ethical training provide Air Force medics with a basic understanding of the laws of war and acceptable conduct in war. Understanding the culture of our adversary and what makes our enemies behave the way they do is just as an important concept than any other deployment requirement. All medical personnel deploying with an AFTH or EMEDS should have in depth exposure to the cultural influences of the country they are going to.

All personnel participating in multinational operations normally receive as part of their predeployment activities an orientation to the culture, languages, and

religious beliefs prevalent in the AO. Medical personnel must ensure they understand the medical considerations presented by these customs and beliefs. Cultural or religious norms may affect a patient's compliance with a prescribed medical regimen, may prohibit the use of blood and blood products, or may restrict the use of certain food products, thereby affecting the patient's nutritional status.⁷³

Historically, cultural competence training has been minimal for most Air Force medics. Reduced to either self-study programs or a 15 minute predeployment country brief, many medics have been deficit in their cultural training prior to a deployment.

Understanding the behaviors, religious practices, shared beliefs, and value system of a culture will undoubtedly increase the clinicians' ability to render holistic care, even to an adversary. There are, however, an assortment of concerns regarding cultural triggers for violence, particularly those practices and rituals of a culture, that when disrespected can lead to outrage and disruption by the detainees.⁷⁴ Cultural triggers are offensive or improper actions that offend a particular person or cultural group. The person or cultural group then decides if the behavior is unacceptable.

So what are some potential cultural triggers that medical personnel need to be conscious of? Having communicated with several cultural anthropologists, the importance of understanding broad cultural concepts is in the best interest of all parties. Topics related to touch, cleanliness, male-female interactions, blood and other bodily fluids, and modesty will be a good starting point for training. One example of why predeployment cultural preparedness is necessary occurred in 2004 in the AFTH. The incident occurred between a detainee and female nurse while the detainee was preparing to read the Qur'an. The detainee was performing wudu ablution, a ritual of cleansing with water before touching the Qur'an.⁷⁵ The nurse interrupted this process because a procedure (non-urgent) needed to be performed, of note; the nurse had no Muslim cultural or religious training prior to her deployment. At this point, "the detainee was in

a pure state and the touch of a female had soiled or threatened to soil that state. The detainee's anger was very likely culturally incited but probably based principally in the human condition and the perception of being illegally or unjustifiably detained.”⁷⁶ Medical personnel must respect the detainee’s time to pray and avoid interruptions during the prayer.⁷⁷

Other triggers for hostility could include not having same sex medical personnel for detainees, which can be challenging, due to staffing limitations. Muslim males, and especially females, are uncomfortable when treated by opposite sex medics. Medics should also limit the exposure of the detainee’s body and only show what is necessary during procedures or exams. Limit eye contact and do not touch while talking to the detainee if practical and possible.⁷⁸ Fasting presents cultural dilemmas, medics need to have an understanding about forcing Muslims detainees to take oral medications, receiving immunizations, or participating in any blood tests.⁷⁹ Medical staff, to include pharmacists, should have natural medical treatments available (if feasible)⁸⁰ since some detainees fear that western medicine will harm them and affect their consciousness.⁸¹ Most Muslims are committed to the “Halal” (something that is permissible in Muslim religion), so providing the detainees with food that is “Halal” (e.g. no pork) may make the detainees feel untroubled about their incarceration and perhaps more collaborative.⁸²

Medical personnel will benefit from predeployment lectures in a variety of topics to include mirror imaging, cultural competency, cultural intelligence, and cultural health to name a few.

Mirror imaging is part of a larger set of problems called ethnocentrism. What it boils down to is the belief that your own culture is the normal and right way of doing things and everything else is abnormal or wrong and needs to be corrected. There is nothing wrong with making your own personal judgments about the way people live. However, when you are interacting with people from another culture, it is easy to misjudge their intentions, motivations, and concerns.⁸³

The MCIA Culture Generic Intelligence Requirement Handbook (still in draft format) outlines some of these topics, which attempts to educate readers by explaining key cultural components mentioned previously. Medics need to recognize cultural learning does not begin with the population itself, but more so with first identifying our own preconceptions, ethnocentrism, as well as our propensity to push our own cultural beliefs on others, often unintentionally⁸⁴.

The MCIA states that this is one key reason why cultural training should be taught before and during the course of a deployment. Unfortunately, this training is not as abundant to the masses that deploy, Air Force medics in particular. A senior Naval medical staff member at GITMO had remarked, “I did not receive any formal preparation prior to going to GITMO. The psychologist there gave me a bunch of stuff to read. The Koran was important, as was the Manchester document. I also read some psychology journal articles on treating Muslims. I had mostly OJT.”⁸⁵

The importance of cultural competence in an expeditionary setting is a priority for all branches of service. The realistic training platforms, such as the detainee operations centers, are on way to provide Airmen with training. The Air Force has created several training venues in the past three years to bolster culture competence. In 2006, ADLS posted several culturally relevant topics to the web site to include Iraq and Afghanistan country familiarization. Again, this training is CBT without a “hands on” component, but does support the Expeditionary Skills Training (EST) that is needed to maintain cultural proficiency.⁸⁶ In 2008 the Cross-Culturally Competent Airman (3C) training program was introduced to the AF and implementation will occur in a multitude of settings spanning the Airmen’s entire career.⁸⁷ 3C will prepare AF personnel by providing tiered training consisting of culture general and culture specific training. Culture general topics (Tier 1 & 2A) will be taught during initial accessions and professional

military education (PME) for both officer and enlisted. ADLS culture courses, as previously mentioned, are an example of the Tier 2A training that will reinforce the Airmen's cultural proficiency.⁸⁸

Culture specific training will include predeployment training (Tier 2B), deployment location specific/mission specific training (Tier 3), and advanced culture specific training tailored to the Airman's operational requirements (Tier 4). This training will prepare Airmen with the knowledge and training to function in a complex cultural environment. The 3C program will provide medics the ability to effectively act in a cross cultural environment and ensure mission success.⁸⁹ More importantly, this cultural information may help to avoid misunderstandings and create a less-hostile environment. All of these recommendations are helpful; however, it will by no means make the medic a subject matter expert on Muslim culture. Developing a rapport and respecting rituals and norms is vital.

Ethical Considerations

Medical personnel may have mixed emotions about rendering care to an insurgent who may have killed one of their fellow Americans. It is indeed a tough scenario and not a new dilemma for medics in a war zone. This is the ethical quandary that medical personnel need to have a full understanding of before they are asked to deliver care in a combat zone. Applied theoretical and practical training in ethics will delineate whether the actions of a medic will be sound. Our own value system and the oaths we have taken to protect and serve or do not harm will be a considerable indication of how medics will conduct themselves in a combat environment. The World Medical Association summed it up in this paragraph,

Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as established in the International Code of Medical Ethics of the World Medical Association. The primary obligation of physicians is to their patients; in performing their professional duty, their conscience should be their guide.⁹⁰

Medics in general need ethical training, with respect to detainees/POW care, prior to any deployment. The Air Force, as mentioned earlier in the paper, does provide Medical Ethics and Detainee Healthcare Operations CBT but there needs to be more. Scenario based training that creates realistic ethical dilemmas is one way that a medic can determine if they will make the right decisions when tough calls need to be made. Ethical dilemmas do not occur in a vacuum, quite often, they occur when stress is at the highest level and in many instances, the decisions made are not fully understood for days, weeks, or months later. The Detainee operations course has two blocks of instruction that provide students with this type of information that can prepare medics for some of these ethical challenges.

With GWOT, there has been substantial attention in the world media regarding the use of torture to gain critical information that could save American lives. Medical personnel have been implicated in participating either directly or indirectly during interrogations that allegedly involves torture. It is DOD policy that medical personnel do not participate in the interrogation process as stated by DODI 2310.08E,

Medical personnel shall not be used to supervise, conduct or direct interrogations.” The only exceptions to this rule are health care personnel assigned to or providing direct support to Behavioral Science Consultants and Armed Forces Medical Examiner personnel.⁹¹

Furthermore, can a physician certify a detainee physical fit to be interrogated? Again, according to the DOD policy “health care personnel can certify or participate in the certification of the fitness of detainees for and the administration of treatment or punishment but only if that treatment or punishment is in accordance with applicable law.”⁹²

Medical commanders have a stake in ensuring that medics are trained according to doctrine. Medics should receive additional training on how to report violations of ethical care and abusive treatment. A thorough understanding of policies, procedures, and directives is

essential in ensuring ethical violations do not occur. Healthcare providers in the field come under constant pressure such as the detainees infuriating them, the stress of the environment, deficient training, or pressure to conform to unethical methods of gaining intelligence. The imperative here is that medics must resist what they believe to be unethical and report. Again, if the medic at the lowest level is not trained to understand these concepts then leadership becomes responsible for the failures in the field.

Summary and Conclusions

As warfare changes, our approaches to medical training should change as well. The GWOT has prompted the U.S to rethink its policies on detainee operations with respect to humane treatment and care. After Abu Ghraib, the world presumably looked at our actions and realized that even the United States struggled with the concepts of LOAC and humane treatment. However, the actions of a few do not necessarily represent the actions of the entire military. Medical detainees in this war are required to be treated humanely and in accordance with the same protections as POWs under the laws of the Geneva Convention.

Groundbreaking and innovative new training was required. The U.S needed to demonstrate to the world that we do respect the covenants of war and humanitarian law. The Army moved quickly to establish training platforms that would prepare their soldiers (to include medics) at locations such as the Detainee Operations Center in Washington, Camp Shelby, and Fort McCoy.

The fundamental premise of success in combat is training and preparedness. Healthcare providers must follow the same principles as an infantry unit, “train as we fight”, or in the case of the AFMS “train as we care.” The expectation that medics can learn as they go is a set up for failure and could result in serious injury or loss of life. A detainee operations mission in an

AFTH or a EMEDs is fundamentally the same as a TIF. More simplistically, it has basic components: detainees that are wounded or recovering from wounds, guards, enhanced security protocols, and a vulnerable population...the medical staff.

Air Force medics have a myriad of clinical training platforms available to prepare for war. Top Sustainment Training to Advance Readiness (TopSTAR-two week didactic/clinical training), Center for Sustainment of Trauma and Readiness Skills (C-STARS), Self Aid-Buddy Care, Medical Unit Readiness Training (MURT), Unit Type Code (UTC) training, Just in Time Training (JIT), and Readiness Skills Verification (RSV) training. However, very few of these training platforms have detainee operations training built in. MURT and UTC training have some component of detainee operations, but training varies from base to base. Currently only two UTC's have mission essential tasks (METLS) that address detainee operations.

Ideally, comprehensive and realistic program development is necessary if AFTHs are going to be in the business of caring for detainees. The AFMS should investigate the possibility of developing their own training courses specific to unique AFMS requirements. Training should be melded with existing AF and Army training platforms. The Detainee Medical Operations and Ethics web-based training on mshlearn provides AF medics with basic training in Geneva Conventions, Law of War, and medical ethics. But as previously stated, these modules need to be supported by a hands on component in a believable training environment. The Army should remain as the lead agent with its current detainee operations programs. Bottom line is that no matter who is responsible for detainee operations training it should be practical, accessible, and universal across the services.

The AFMS should also investigate the possibility of additional sources of information, such as a Detainee Operations Handbook for medics, similar to the Airman's manual. The Army

is currently developing a reference handbook for the full spectrum of detainee operations that can be used jointly with the Air Force and other services. Air Force Instruction (AFI) 41-106 discusses requirements for deployment training. An excerpt from the AFI states,

Additional training may be required to meet theater-specific requirements. These theater-unique training requirements will be identified in deployment reporting instructions or tasking line remarks. Deployment training requirements include those skills required for personnel to perform the full scope of practice for their AFSCs in a deployed setting.⁹³

Detainee medical operations with emphasis on how medics can be mentally, emotionally, and physically prepare is just one more necessary training piece to add to the checklist. Medical personnel need to thoroughly comprehend the environment they are deploying to. In order to accomplish this task additional training on many of the aforementioned subjects is needed. Muslim cultural awareness, personal safety awareness, detainee escort procedures, resistance to elicitation, interact with detainees, ethical treatment of detainees in the delivery of healthcare, detainee medical games, and unarmed self defense is a must.⁹⁴ The world is watching how the US is treating the detainees; AFMS needs to be prepared as well...are AF medics ready for the challenge?

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- ²⁸ *Ibid.*, I-9.
- ²⁹ *Ibid.*, I-9, I-10.
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- ³³ *The Military Commander and Law, Law of Armed Conflict*, 626.
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- ³⁶ *Ibid.*
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- ³⁸ Gebhardt, *The Road to Abu Ghraib: U.S. Army Detainee Doctrine and Experience*, 44.
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