How Hospital Stays Resemble Enhanced Interrogation

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The 1983 *Human Resource Exploitation Training Manual* from the Central Intelligence Agency (CIA) gives instructions on how to conduct enhanced interrogations of prisoners (1). Studying the parallels between these interrogation techniques and the experience of many hospitalized patients puts forth a haunting revelation—hospital stays unintentionally resemble torture.

The manual begins by discussing the transition of the prisoner into a harsh, new environment with a purposely disruptive arrest, the sudden loss of freedom wreaking predictable psychological havoc. Acute illness similarly creates an abrupt transition to the hospital environment, although the abruptness is not purposeful.

The CIA manual goes on to recommend creating a psychologically unsettling environment to disrupt the prisoner's mental state. Windows "should be set high in the wall with the capability of blocking out the light," thereby disrupting "the subject's sense of time." Heat, air, and light should be "externally controlled," to undermine the prisoner's autonomy (2). One could draw parallels to the hospital setting, where rooms are designed to maximize the functionality of medical interventions, inadvertently limiting the patient's ability to manipulate their environment. Patients often lack access to thermostats and windows. Shared rooming creates unwanted sources of sound, light, and smells.

With the means of arrest established and the environment in place, the manual inventories interrogation techniques designed to degrade autonomy and willpower. Subjects are to be befuddled with nonsensical questions, interrupting their responses with more questions, thereby leaving prisoners with a sense of "eerie meaninglessness." It is plausible that unintentional use of medical jargon has a similar effect. The manual also recommends providing subjects with "ill-fitting clothing" to undermine their identity. It seems likely that drafty hospital gowns have a similar effect. Add in colored socks that prominently segregate the ambulatory from those deemed functionally impaired, and it would be no surprise for patients to feel loss of identity.

Interrogators are directed to humiliate subjects by performing a complete physical, including examination of all orifices, not unlike a thorough physical examination at the beginning of a hospital stay. Indeed, patients are often subject to a series of physical examinations as they work their way through various health care environments.

The CIA emphasizes the importance of violating subject privacy, instructing interrogators to stay at the prisoners' sides even when they go to the bathroom. In a similar manner, invasive observation is often the norm in health care environments. Patients are monitored with wires, blood pressure cuffs, and pulse oximetry and are supervised while sitting on bedside commodes. Undoubtedly, such close supervision is frequently necessary, but that does not minimize the psychological toll such loss of privacy takes on patients.

The CIA instructs interrogation facilities to keep the environment unpredictable, disrupting prisoners' sense of time by randomly altering the cycles of light and darkness and depriving prisoners of sleep. Eating schedules are to be random. Once again, the parallels to hospital stays are striking. Exposure to bright lights and loud beeping occurs around the clock, and sleep is interrupted by random vital sign checks, medication delivery, and blood draws. Meals are often delayed for procedures.

The basic premise of enhanced interrogation is to revoke people's sense of control, inducing a state of psychological regression where prisoners "lose capacity to deal with complex situations." Clearly, clinicians do not set out to cause patients to psychologically regress. Indeed, our call to benevolence and nonmaleficence keeps the patient's well-being our highest priority. While enhanced interrogation involves deliberate attempts to create mental distress to weaken resolve, hospital care unintentionally creates mental distress, often leading to "posthospital syndrome," which is characterized by posttraumatic stress disorder, sleep disturbances, anxiety, depression, and weight loss or gain and increases the risk for readmission (3, 4).

Recognizing the parallels between enhanced interrogation and hospitalization is the first step to improving the patient experience.

First, empathize with the patient's loss of control. When they do not understand our questions or become disconnected from the realities of their illness, we should recognize these as normal responses to abnormal circumstances. Rather than conclude that patients are "difficult," we should remember that it is the experience we are exposing them to that is difficult. Labels like "good patient" or "bad patient" are easy to assign, but these behaviors might represent attempts to cope with loss of control (5). "Good patients" may demonstrate full adherence out of a sense of helplessness, and "bad patients" may be reactive because of their perceived loss of freedoms. Both populations are at risk for hospital-related complications.

Hostility to staff members and nonadherence may represent psychological compensations for an environment in which patients hold no authority. Providers can counter these subconscious barriers by taking away physical ones. When patients do not need hospital gowns, we should invite them to wear their own clothing. When patients do not require vital signs every 4 hours, or blood draws at 4 a.m., we should institute sleep protocols (6). Ambulation outside of sleeping quarters should be encouraged. And when patients are

This article was published at Annals.org on 21 July 2020.

isolated in their rooms, we should give them the sovereignty to decorate. If food tastes better from home, let it be brought in.

Second, when pain and disruption are unavoidable, we should explain this to patients. The psychology of enhanced interrogation depends on making unpleasant experiences feel random and confusing. Telling patients why they need to wear hospital gowns or have their vital signs checked in the middle of the night can reduce the psychological toll of those disruptions.

Health care providers are naturally motivated to improve patient experiences. When patients are admitted to hospitals, their illnesses often take away their sense of control. Hospitalization can take away more of it. Recognition is the first step toward improving the hospital experience. Small efforts, when combined, can have a big impact. The next time you enter a patient's room, take a second to see if they want to open the window shades or reset the thermostat, and for that moment, let them enjoy the sweet taste of freedom.

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Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M19-3874.

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Ann Intern Med. doi:10.7326/M19-3874

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Final approval of the article: H. Geyer, K. Mishark, P.A. Ubel.