GlobalResearch
Center for Research on Globalization

Ex-Guantanamo Official Was Told Not to Discuss Policy Surrounding Antimalarial Drug Used on Detainees

By Jason Leopold
Global Research, December 21, 2010
truth-out.org 21 December 2010

Theme: Crimes against Humanity, Law and Justice

Military officials were instructed not to publicly discuss a decision made in January 2002 to presumptively treat all Guantanamo detainees with a high dosage of a controversial antimalarial drug that has been directly linked to suicide, hallucinations, seizures and other severe neuropsychological side effects, according to a retired Navy captain who signed the policy directive.

Capt. Albert J. Shimkus, the former commanding officer and chief surgeon for both of the Naval Hospital at Guantanamo Bay and Joint Task Force 160, which administered health care to detainees, defended the unprecedented practice, first reported by Truthout earlier this month, to administer 1250 mg of the drug mefloquine to all "war on terror" prisoners transferred to Guantanamo within the first 24 hours after their arrival, regardless of whether they had malaria or not. The 1250 mg dosage is what is used to treat individuals who have malaria and is five times higher than the prophylactic dose given to individuals to prevent the disease. One tropical disease expert said there is no "medical justification" for the practice.

Mefloquine is also known by its brand name Lariam. It was researched by the US Army in the 1970s during the Vietnam War and licensed by the Food and Drug Administration (FDA) in 1989. Since its introduction, it has been directly linked to serious adverse effects, including depression, anxiety, panic attacks, confusion, bizarre dreams, nausea, vomiting, sores, hallucinations and homicidal and suicidal thoughts.

Although there were two media reports in 2002 that quoted Shimkus saying "war on terror" detainees were given antimalarial medication, neither he nor any other military or Pentagon official ever disclosed to lawmakers or military personnel who raised questions about the efficacy of mefloquine, that mass presumptive treatment was the policy in place at Guantanamo.

"There were certain issues we were advised not to talk about," Shimkus told Truthout in an interview, explaining the reason the policy was never publicly disclosed. He could not recall who told him not to discuss the issue.

Shimkus, who is now an associate professor of national security studies at the Naval War College in Newport, Rhode Island, said officials from the Centers for Disease Control (CDC), the Navy Environmental Health Center (NEHC) and the Armed Forces Medical Intelligence Center at Fort Detrick, Maryland, which is part of the Defense Intelligence Agency, were all involved in the discussions that resulted in the issuance of a January 23, 2002, "Infection

Control" Standard Operating Procedure (SOP) that called for the mass presumptive treatment of malaria using mefloquine.

Detainees started arriving at Guantanamo two weeks earlier and were held in a detention center known as Camp X-Ray.

The "Infection Control" SOP, which was signed by Shimkus and has not been previously released, says, "detainees are native to a region plagued by a number of infectious diseases. It is estimated that a number of these detainees will carry one or more of these illnesses upon arrival … Empiric therapies will include … mefloquine 1250 mg."

Medical literature usually describes "empiric therapy," or presumptive treatment for malaria, as the administration or self-administration of antimalarial drugs for symptomatic individuals, or occasionally groups of at-risk patients, who do not have access to laboratories or medical facilities and in whom malaria cannot be formally diagnosed.

At Guantanamo, however, all detainees, whether they had symptoms or not, were given laboratory tests to determine if they had malaria, and doctors were accessible "24/7" in the event symptoms started to surface, Shimkus said, calling into question the rationale for mass presumptive treatment.

Shimkus said the NEHC bore the primary responsibility for recommending that mefloquine be administered to all detainees in treatment doses, but there was consensus among the various government agencies about using the drug in this way.

"There was no one that said, 'Captain, this is not the way to go,'" Shimkus said. "I did not do anything in isolation. Any policy would have been approved by a higher authority" up the medical chain of command.

Shimkus could not recall the names of the officials from the various government agencies who agreed with and signed off on the policy. Nor could he identify his immediate medical supervisor, a colonel at United States Southern Command (SOUTHCOM), which is responsible for contingency planning and operations in Cuba, who Shimkus said would have also been involved in the decision.

Cuban Government Concerns

Shimkus said one of the reasons that factored into the decision to presumptively treat war on terror detainees with mefloquine was concerns raised by the Cuban government.

In an interview with Miami Herald reporter Carol Rosenberg in February 2002, Shimkus said he and other medical officers stationed at Guantanamo met with Cuban doctors and government officials on February 8, 2002, to "reassure the government that suspected terrorist prisoners are not introducing malaria into" Cuba, "which has been free of the mosquito-borne disease for 50 years."

Rosenberg reported on February 22, 2002, that steps taken to prevent the spread of malaria at Guantanamo included "impregnating the uniforms of both prisoners and troops who handle prisoners with mefloquin [sic] and other agents to kill the parasite … " The Herald's

February 22, 2002, report was the first and only time mefloquine use at Guantanamo has ever been mentioned. But Rosenberg's report did not state that Shimkus had already signed a policy directive authorizing mass presumptive treatment.

Shimkus told Truthout he could not recall specific details of his discussions with the Cubans. He did not respond to follow-up questions about Rosenberg's characterization regarding the use of mefloquine.

Just three days prior to the publication of the Herald's report, Navy Capt. Alan "Jeff" Yund appeared before the Armed Forced Epidemiological Board (AFEB) and was queried about malaria at Guantanamo.

But Yund, the Navy's liaison officer to AFEB, did not disclose that mefloquine was being administered to detainees. He said he believed detainees who were infected with the disease would be treated on a case-by-case basis with a different antimalarial drug known as primaquine, and that other steps would be taken to protect against mosquitoes.

Yund told Truthout via email that he did not refer to mefloquine during the AFEB briefing because, "I do not recall being involved in any consultations regarding the use of mefloquine at Guantanamo and do not recall being aware that it was being used there."

Yund declined to comment further.

Shimkus could not say why Yund was unaware that mefloquine was being used as a form of mass presumptive treatment at Guantanamo.

The use of mefloquine at Guantanamo was not mentioned during numerous other AFEB briefings, particularly one held in May 2003, where concerns were raised by members of the board about the drug's severe neuropsychiatric side effects, which US military personnel who had taken mefloquine in 250 mg prophylactic doses had been complaining about.

Red Flags Raised

Shimkus said he was aware of the alternatives and noted that at one point the antibiotic drug doxycycline and Malarone were under consideration, but the latter had only been approved by the Department of Defense in 2000 and had not been in widespread use yet. Mefloquine, Shimkus said, was considered efficient and effective.

But at an April 16, 2002, meeting of the Interagency Working Group for Antimalarial Chemotherapy, which included Defense Department representatives, participants concluded that study designs on mefloquine were flawed or biased and based on "sensational or [at] best marketed information."

The Working Group, which included representatives from the State Department, the CDC and FDA, stated, "Sufficient evidence exists to raise the question whether the neuropsychiatric adverse events of mefloquine are frequent enough and severe enough to warrant limiting its use …" The group called for additional research, and warned, "Other treatment regimes should be carefully considered before mefloquine is used at the doses required for treatment."

Additionally, in October 2002, William Winkenwerder, the assistant secretary for defense,

admitted that “recent press articles and scientific studies have raised concerns regarding the adverse effects associated with mefloquine use.”

Winkenwerder’s admission was made in a letter written in response to questions raised by John McHugh, then chair of the subcommittee on military affairs for the House Armed Services Committee. The letter said, “recent peer-review reports” showing adverse events levels associated with mefloquine are “much higher than previously reported.” Winkenwerder told McHugh, now secretary of the Army, that the CDC had initiated a review in 2001, which was then still underway, of all chemoprophylactic drugs, including mefloquine.

Shimkus said he did not believe Winkenwerder was part of the consulting team who signed off on administering treatment doses of mefloquine to detainees. But Shimkus said the policy was “well-known in the [military] medical community.” Winkenwerder did not respond to calls for comment.

The use of mefloquine as a mass presumptive treatment at Guantanamo continued until at least July 2005, despite the presence of ongoing warnings.

In June 2004, the CDC issued a new set of guidelines on malaria treatment, which warned that mefloquine “is associated with a higher rate of severe neuropsychiatric reactions when used at treatment doses,” and recommended that mefloquine be used “only when … [other] options cannot be used.”

As far back as 1990, the CDC warned in a set of recommendations for malaria prevention for travelers that mefloquine should not be used for presumptive self-treatment “because of the frequency of side effects, especially dizziness, which has been associated with therapeutic dosages of mefloquine.”

“This was a one time treatment only [for detainees],” Shimkus said. “My focus on mefloquine was specifically for preventing malaria from occurring.”

However, other Guantanamo documents obtained by Truthout say that on February 28, 2002, 59 detainees allegedly refused to take medication, including antimalarial drugs, and noted that the “series must start over.” It is unclear whether this included readministration of mefloquine, or whether the “series” described included further antimalarial doses of primaquine or cholorquine, also administered to the detainees.

Maj. Remington Nevin, an Army public health physician, who formerly worked at the Armed Forces Health Surveillance Center and has written extensively about mefloquine, previously told Truthout the decision to administer high doses of the drug, even as a one-time treatment “is, at best, an egregious malpractice.”

Nevin added, “many dozens of detainees, possibly hundreds” likely experienced side effects “as severe as those intended through the application of ‘enhanced interrogation techniques.'”

Truthout was unable to locate a single malaria expert who was willing to go on the record to defend the government’s policy of mass presumptive treatment of the disease using mefloquine or any other antimalarial drug.

Shimkus told Truthout that, “clinically,” he could not recall if any detainees experienced any

side effects associated with taking mefloquine, but if they did, that data would have been noted in their medical records.

“We have robust medical records,” Shimkus said. “If anything occurred that was a cause for concern it would have been documented in their medical records.”

But the government has refused to release Guantanamo detainees’ medical records to the media or to their attorneys citing, among other reasons, privacy concerns.

As first documented in a separate report on mefloquine use at Guantanamo published earlier this month by Seton Hall University School of Law’s Center for Policy and Research, medical files for detainee 693 released by the Defense Department in connection with his alleged suicide at the prison facility in June 2006, contradict Shimkus’s assertions. Those records show that two weeks after the detainee was given mefloquine in June 2002, he was interviewed by Guantanamo medical personnel and reported that he was suffering from nightmares, hallucinations, anxiety, auditory and visual hallucinations, sleep loss and suicidal thoughts.

A Guantanamo medical officer who interviewed the detainee, however, did not state that the detainee may have been experiencing mefloquine-related side effects in notes he took evaluating the detainee’s condition.

Shimkus dismissed the significance of the medical officer’s failure to connect the detainee’s psychological state to the possible side effects resulting from mefloquine, stating that the medical officer may have been unaware “the patient had taken [the drug], because there was a lot of turnover of staff at that point.”

Scott Allen and Vince Iacopino, medical doctors affiliated with Physicians for Human Rights, a doctors’ organization based in Cambridge, Massachusetts, said, “the questionable use of mefloquine for malaria prevention at Guantanamo underscore the need for transparency of detention policies and procedures” at the prison facility.

“Benefits Outweighed Risks“

Shimkus, who is a nurse by training, acknowledged that the mass presumptive treatment of malaria using mefloquin was unprecedented. However, he said the “benefits outweighed the risks.”

When asked, Shimkus did not indicate that contraindications for the use of mefloquine, such as pre-existing cases of post-traumatic stress disorder, anxiety, seizures. or other mental illness, which would have heightened mefloquine’s side effects, were ever pursued for the individual detainees. He simply reiterated that the benefits of administering treatment doses of mefloquine outweighed the risks.

Yet, when told that the Defense Department took a radically different approach a decade earlier, when thousands of Haitian refugees housed at Guantanamo were first tested to determine if they had malaria and, only then, were given a treatment dosage of a different medication, chloroquine, if they had the disease, Shimkus said war on terror detainees “were a different cohort of individuals.”

“You have to remember that this was in the context of February 2002,” Shimkus said. “The detainees came from Afghanistan and other areas that may have been chloroquine

resistant."

Moreover, in two articles published in 2002, Shimkus claimed statistics showed that 40 percent of Afghanistan's population was infected with malaria. But according to figures from the World Health Organization, in 2002, the number infected in Afghanistan was about 13 percent.

Shimkus also indicated that malaria cases at Guantanamo could have led to a public health crisis at the base, and reintroduction of malaria into Cuba. Once an outbreak begins, Shimkus told Truthout, one "loses control" of the situation and there is an epidemic.

However, when the CDC examined the influx of tens of thousands of refugees to the United States from hyper-epidemic sub-Saharan Africa, where the falciparum form of malaria kills more than a million people yearly, they concluded that "sustained malaria transmission" in a nonmalarial endemic country, like the US, from this population "would be unlikely."

Still, the CDC called for mass presumptive treatment (with a drug other than mefloquine) of these refugees before they came to the US – mainly because they feared many US doctors wouldn't recognize malaria symptoms – but noted that such mass presumptive treatment from other parts of the world, including Afghanistan, was not recommended, because "the risk and cost of post-arrival presumptive treatment currently outweighs the potential benefits."

Of the more than 700 detainees held at Guantanamo, only four tested positive for malaria, all in January and February 2002.

But Shimkus still defended the mass administration of mefloquine, saying, "One [infection] is too many." Shimkus said he believes he and other military officials "made the right policy decisions based on the information we had to prevent the introduction of malaria" in Cuba and protect the health of the detainees.

Shimkus said after he retired from the military he became involved with the Open Society Institute, funded by the Soros Foundation, and has since taken a role in the work the organization has done to raise awareness about abusive interrogation measures contained in the Army Field Manual.

Articles by: Jason Leopold