

## First, Do No Harm: Health Professionals and Guantánamo

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I would like to thank the organizers of this event for this important teach-in and convening this panel to address the ways in which health professionals have become embroiled in human rights violations against detainees in U.S. custody. Just as the embrace by the Bush Administration of torture as an interrogation strategy led to a corrosion of law, so did it undermine the ethics of the health professions and the integrity of the tradition, within the military, of medical independence and commitment to the health of soldiers and detainees. What is surprising is not that physicians, psychologists, and other health workers can become enmeshed in the machinery of torture, from design to execution to monitoring—there is a long history of such engagement.<sup>1</sup> Rather, what is startling is the ease with which this role was officially developed and new rules and ethical standards that were adopted to facilitate it.

The shift began in 2002, following the Bush Administration's re-interpretation of laws designed to prevent and criminalize the prac-

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<sup>1</sup> See, e.g., British Medical Association, *Medicine Betrayed* (1992); Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity and the War on Terror* (2006); Physicians for Human Rights, *Torture and Turkey and its Medical Accomplices* (1996); Eric Stover & Elena Nightingale, *The Breaking of Bodies and Minds* (1985); M. Gregg Bloche, *Uruguay's Military Physicians: Cogs in a System of State Terror*, 255 JAMA 2788 (1986); Vincent Iacopino et al., *Physician Complicity in Misrepresentation and Omission of Evidence of Torture in Post-Detention Medical Examinations in Turkey*, 276 JAMA 396 (1996); Chen Reis et al., *Physician Participation in Human Rights Abuses in Southern Iraq*, 291 JAMA 1480 (2004).

tice of torture, starting with the White House General Counsel's repudiation of the Geneva Conventions as a guide to interrogation of detainees captured in Afghanistan<sup>2</sup> and the Department of Justice's infamous reinterpretation of the statute criminalizing torture.<sup>3</sup> These legal strategies opened the door to the widespread use of torture. By late 2002, the Secretary of Defense approved the use of interrogation techniques that included the use of stress positions, sleep deprivation, isolation, threats, the use of dogs to induce fear, and many forms of humiliation.<sup>4</sup> The Guantánamo interrogation logs of the so-called twentieth 9/11 hijacker, Mohammed al-Qahtani, obtained by *Time Magazine*<sup>5</sup>, reveal how interrogators, frustrated by the detainees' unwillingness to provide helpful responses after many weeks of interrogation used newly authorized methods of torture. They also reveal how physicians and psychologists became caught up in the vortex of torture.

The centerpiece of the interrogation strategy was long-term isolation and sleep deprivation, and al-Qahtani was interrogated for eighteen to twenty hours a day for forty-eight to fifty-four consecutive days while he was in isolation, which extended over a period of 160 days.<sup>6</sup> At various times interrogators used techniques including stress positions, exploitation of phobias, threats, use of military dogs, temperature extremes (including seventeen occasions when water was poured over his head), incessant loud music, and many forms of degradation.<sup>7</sup> Among many other humiliations, al-Qahtani was forced to perform dog tricks on a leash, engage in sexually degrading acts in-

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<sup>2</sup> Memorandum from Alberto R. Gonzales to President George W. Bush re: Draft Decision Memorandum for the President on the Applicability of the Geneva Conventions to the Conflict in Afghanistan (Jan. 25, 2002), *reprinted in* THE TORTURE PAPERS 118 (Karen J. Greenberg & Joshua L. Dratel eds., 2005).

<sup>3</sup> Memorandum from Office of Legal Counsel, U. S. Dep't of Justice, to Alberto R. Gonzales, Counsel to the President, re: Standards of Conduct for Interrogation under 18 U.S.C. §§ 2340–2340A (Aug. 1, 2002), *reprinted in* THE TORTURE PAPERS, *supra* note 2, at 172; *see generally* JOSEPH MARGULIES, GUANTÁNAMO AND THE ABUSE OF PRESIDENTIAL POWER 89–95 (2006); David Luban, *Liberalism: Torture and the Ticking Bomb*, in THE TORTURE DEBATE IN AMERICA 35–83 (Karen J. Greenberg ed., 2006); PHYSICIANS FOR HUMAN RIGHTS, BREAK THEM DOWN: SYSTEMATIC USE OF PSYCHOLOGICAL TORTURE BY U.S. FORCES (2005), *available at* <http://www.physiciansforhumanrights.org/library/documents/reports/break-them-down-the.pdf> [hereinafter BREAK THEM DOWN].

<sup>4</sup> BREAK THEM DOWN, *supra* note 3, at 72–101.

<sup>5</sup> Adam Zagorin & Michael Duffy, *Inside the Interrogation of Detainee 063*, TIME, June 20, 2005, at 26, *available at* <http://www.time.com/time/magazine/article/0,9171,1071284,00.html?internalid=AM2>.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

cluding standing naked before female interrogators and wearing women's underwear, was subjected to having female interrogators engage in lap dances and massage his back and neck, and was forced to dance with a male interrogator.<sup>8</sup> A female interrogator squatted over his Koran.<sup>9</sup> He was also told that his sister was a whore, that he had homosexual tendencies, and that other detainees knew of this.<sup>10</sup>

While a Department of Defense review concluded that none of these techniques, either alone or in combination, violated prohibitions against torture and cruel, inhuman, and degrading treatment,<sup>11</sup>

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* The techniques used are also described in an official report of the Department of Defense. RANDALL SCHMITT, ARMY REGULATION 15-6: FINAL REPORT, INVESTIGATION INTO FBI ALLEGATIONS OF DETAINEE ABUSE AT GUANTÁNAMO BAY, CUBA DETENTION FACILITY (2006), available at <http://www.defenselink.mil/news/Jul2005/d20050714report.pdf> (as amended June 9, 2006).

<sup>10</sup> Zagorin & Duffy, *supra* note 5.

<sup>11</sup> Schmitt, *supra* note 9. The United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 1, Dec. 10, 1984, 108 Stat. 382, 1465 U.N.T.S. 85, available at [http://www.unhchr.ch/html/menu3/b/h\\_cat39.htm](http://www.unhchr.ch/html/menu3/b/h_cat39.htm). Article One of the Convention Against Torture defines torture as:

any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

*Id.* In ratifying the Convention, the Senate adopted reservations, declarations and understandings concerning its interpretation by the United States. See Michael John Garcia, *CRS Report to Congress, The U.N. Convention Against Torture: Overview of U.S. Implementation Policy Concerning the Removal of Aliens* (Updated April 4, 2006), available at <http://trac.syr.edu/immigration/library/P1339.pdf>. These included a definition of severe mental pain or suffering, which was also incorporated in a criminal statute enacted by Congress. That definition is

the prolonged mental harm caused by or resulting from—

- (A) the intentional infliction or threatened infliction of severe physical pain or suffering;
- (B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality;
- (C) the threat of imminent death; or
- (D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality . . . .

18 U.S.C.S. § 2340(2) (LexisNexis 2007).

the State Department, which is responsible for assessing the human rights record of governments around the world, had long considered these techniques to be violations of international human rights and humanitarian law standards prohibiting torture.<sup>12</sup> The medical and psychological literature is, moreover, replete with evidence that harsh psychological techniques like isolation, severe humiliation, inducement of fear, hooding, and other techniques can bring about severe anxiety, post traumatic stress disorder, cognitive impairment, depression, and even psychotic symptoms.<sup>13</sup> Many of these conditions were indeed apparent to observers at Guantánamo and elsewhere. FBI agents and Red Cross officials reported the mental deterioration of detainees at Guantánamo and even the Department of Defense reported more than 350 acts of self-harm at Guantánamo, including 120 “hanging gestures” in 2003 alone.<sup>14</sup>

The very harshness and danger of the techniques, together with the goal of seeking every advantage in devising interrogation strategies that could break prisoners, led intelligence and defense officials to bring in doctors and psychologists to help—as designers of interrogation strategies, as consultants to interrogators, as “safeguards” and monitors, and as medical interveners when needed. All these roles were apparent in the al-Qahtani interrogation log,<sup>15</sup> and they all became institutionalized as U.S. interrogation strategies developed from 2002 on.

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The Third Geneva Convention protects prisoners of war. Geneva Convention Relative to the Treatment of Prisoners of War arts. 13, 17, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135. Article Thirteen requires that prisoners of war (POWs) must at all times be treated humanely, and that any unlawful act or omission by the detaining power that causes death or seriously endangers the health of a POW will be regarded as a serious breach of the Convention. *Id.* art 13. Article Seventeen provides: “[N]o physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted or exposed to unpleasant or disadvantageous treatment of any kind.” *Id.* art. 17. The provisions of Article Three common to all four of the Geneva Conventions prohibit violence to life and person, including cruel treatment and torture, as well as outrages upon personal dignity—in particular, humiliating and degrading treatment—regardless of whether the conflict is of an international nature or whether a person has POW status. *Id.* art. 3.

<sup>12</sup> For a review of Department of State interpretations of which interrogation practices amount to torture, see Tom Malinowski, *Banned State Department Practices, in TORTURE: DOES IT MAKE US SAFER? IS IT EVER OK?* 139–44 (Kenneth Roth, Minky Worden & Amy D. Bernstein eds., 2005).

<sup>13</sup> BREAK THEM DOWN, *supra* note 3, at 48–71.

<sup>14</sup> Paisley Dodds, *Mass Suicides Attempted at Guantánamo*, ASSOCIATED PRESS, *reported in* PITT. TRIB. REV., Jan. 25, 2005, *available at* [http://www.pittsburghlive.com/x/pittsburghtrib/s\\_296479.html](http://www.pittsburghlive.com/x/pittsburghtrib/s_296479.html).

<sup>15</sup> Zagorin & Duffy, *supra* note 5.

Let me illustrate the last role of doctors and psychiatrists—as medical interveners—first. In the al-Qahtani interrogation there are frequent references to medical monitoring.<sup>16</sup> In the midst of his brutal interrogation, al-Qahtani, in protest, refused to take water, and a medical corpsman reported that he was becoming seriously dehydrated.<sup>17</sup> Eventually he was put under a doctor's care and interrogators allowed an unprecedented twenty-four-hour interruption in the interrogation; but even in the midst of receiving medical care, interrogators continued to deny him sleep by playing loud music.<sup>18</sup> Al-Qahtani's heartbeat became quite slow, and he was transferred to a hospital.<sup>19</sup> Tests including an electrocardiogram, CT scan, and ultrasound were ordered, and a second doctor was brought in.<sup>20</sup> Eventually al-Qahtani was allowed to sleep, and after receiving medical clearance, was "hooded, shackled and restrained in a litter"<sup>21</sup> and brought back for resumption of the interrogation.<sup>22</sup>

It is hard to imagine a more unseemly and unethical role for a physician, who is supposed to be dedicated to a person's well being, than to intervene medically in the midst of ongoing torture—even administering care while the detainee is deprived of sleep<sup>23</sup>—so that torture can continue. That is why the mere presence of a physician while someone is being tortured—not to mention the participation of a physician as a facilitator, enabler, or monitor of torture—has been condemned in ethics codes as a gross violation of core medical values of promoting well-being and doing no harm.<sup>24</sup> The World Medical Association's Declaration of Tokyo, for example, adopted thirty years ago, affirms that "[t]he physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this

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<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> Zagorin & Duffy, *supra* note 5.

<sup>22</sup> *Id.* For additional roles health personnel played in intervening in this interrogation, see Stephen Miles, *Medical Ethics and the Interrogation of Guantánamo 063*, 7 AM. J. BIOETHICS 1 (2007).

<sup>23</sup> Zagorin & Duffy, *supra* note 5.

<sup>24</sup> See, e.g., Principles of Medical Ethics relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 37/194, U.N. Doc. A/37/51 (Dec. 18, 1982) [hereinafter Principles of Medical Ethics].

higher purpose.”<sup>25</sup> It specifically prohibits the physician from engaging in or facilitating torture in any way, including actions “to diminish the ability of the victim to resist such treatment” or even being present when “torture or . . . cruel, inhuman or degrading treatment is used or threatened.”<sup>26</sup> Similar ethical standards have been adopted by other health professions and by the U.N. General Assembly,<sup>27</sup> and the American Medical Association’s own standards are even more explicit regarding evaluation or treatment to enable torture to begin or continue. Its standards provide that “[p]hysicians may treat prisoners or detainees if doing so is in their best interests, but physicians should not treat individuals to verify their health so that torture can begin or continue.”<sup>28</sup>

Despite these admonitions, the participation of medical personnel was fairly common in interrogations conducted by U.S. forces. A survey conducted by the Army Surgeon General revealed that as of mid-2005, seventeen percent of responding health personnel in Afghanistan and ten percent in Iraq stated that they had been present during interrogation.<sup>29</sup> We do not know precisely what role they played, but medical monitoring during harsh interrogation, including clearance to proceed or continue, seems a likely candidate.

A second role physicians and psychologists have played in interrogations is as a purported safeguard. It is unclear whether a physician or psychologist signed off on al-Qahtani’s interrogation, though as discussed below, psychologists were involved in developing it. Later on, however, this role became explicit. A working group that made recommendations to the Secretary of Defense in 2003 advised that certain harsh interrogation tactics should be subject to medical review,<sup>30</sup> and the Secretary of Defense and other commanders re-

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<sup>25</sup> World Med. Ass’n, *Declaration of Tokyo, Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* (as amended May 2006), available at <http://www.wma.net/e/policy/c18.htm>.

<sup>26</sup> *Id.*

<sup>27</sup> Principles of Medical Ethics, *supra* note 24.

<sup>28</sup> AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS, CURRENT OPINIONS, 2005–2006 ed., opinion E-2.067, available at <http://www.ama-assn.org/ama/pub/category/8421.html>.

<sup>29</sup> DEP’T OF ARMY, OFFICE OF THE SURGEON GENERAL, FINAL REPORT, ASSESSMENT OF DETAINEE MEDICAL OPERATIONS FOR OEF, GTMO AND OIF (Apr. 13, 2005), available at <http://www.armymedicine.army.mil/news/detmedopsrprt/detmedopsrpt.pdf> [hereinafter SURGEON GENERAL REPORT].

<sup>30</sup> SEC’Y OF DEF., WORKING GROUP REPORT ON DETAINEE INTERROGATIONS IN THE GLOBAL WAR ON TERRORISM: ASSESSMENT OF LEGAL, HISTORICAL, POLICY AND

quired that interrogation plans involving isolation, sleep deprivation, dietary restrictions, sensory deprivation, and other techniques receive to medical clearance.<sup>31</sup> When Behavioral Science Consultation Teams (“BSCTs” or “biscuits”) were put into place as a formal means of bringing health professionals into the interrogation process, one of the purported functions was indeed to act in a “safety officer role”<sup>32</sup> and be responsible for ensuring that interrogations are conducted in a safe, ethical, and legal manner. This role and official justification remains in place today. The Army’s new field manual on human intelligence gathering, issued in the fall of 2006, for example, eliminates many previously authorized unlawful interrogation techniques, but retains a requirement of medical approval and monitoring for an interrogation strategy called “separation”—a euphemism for prolonged isolation.<sup>33</sup>

Let’s put aside the fact that physicians and psychologists have no training in this “safeguarding” function. Let’s put aside, too, the ethical outrage of requiring medical personnel to sign off on deliberate infliction of physical and mental harm. Let’s even put aside the fact that, as I will discuss in a moment, health professionals were also assigned a function that contradicts this role—to design interrogations that would be “effective,” which could include the possibility of making them harsher. The fact is that, as in other cases in recent history, the dynamic of torture is such that purported safeguards intended to guard against overzealous use of harsh interrogation techniques never work—approvals of interrogators’ increasingly aggressive methods simply become routine.<sup>34</sup> In the absence of an extraordinarily firm and persistent objection by the monitoring health professional, engaging medical personnel in approving interrogation plans and monitoring for “safety” purposes amounts to giving interrogators a green light. At best, this monitoring role requires health personnel to calibrate the degree of harm to be “acceptably” inflicted during an interrogation.

The third role is the most pernicious of all: the direct involvement of health professionals, especially psychologists and psychia-

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OPERATIONAL CONSIDERATIONS 10–18, 18–21 (Apr. 4, 2003), available at <http://www.defenselink.mil/news/Jun2004/d20040622doc8.pdf>.

<sup>31</sup> See BREAK THEM DOWN, *supra* note 3, at 45–47.

<sup>32</sup> SURGEON GENERAL REPORT, *supra* note 29, at 18–15.

<sup>33</sup> U.S. ARMY, FIELD MANUAL 2-22.3, HUMAN INTELLIGENCE COLLECTOR OPERATIONS (2006), app. M (authorizing “separation,” or isolation, up to thirty days or longer, provided certain approvals and “safeguards” are in place).

<sup>34</sup> Leonard S. Rubenstein & Stephen Xenakis, *Torture and Psychological Warfare*, in WAR AND PUBLIC HEALTH (Barry S. Levy & Victor W. Sidel eds., forthcoming 2007).

trists, in the design of interrogation strategies to break down detainees. The al-Qahtani log suggests that psychologists helped design the interrogation plan, with all its aggressive assaults on his mind as well as his body, and advised interrogators along the way. The logs also show that BSCT members directed interrogators to keep al-Qahtani from sleeping, among other instructions.<sup>35</sup> The psychologists, physicians, and others were assigned to BSCTs specifically for the purpose of using their knowledge to assess detainees, design interrogation strategies, and advise interrogators. According to the Army Surgeon General's report, their purposes included "[r]eviewing detainee information"; "[p]roviding [an] opinion on character and personality of detainees"; "[c]onsulting on interrogation plan and approach"; and "[p]roviding feedback on interrogation technique."<sup>36</sup> This role included identifying the vulnerabilities of detainees and helping intelligence officials exploit them. According to the report, interrogators are taught to interact with BSCT personnel, to learn the medical history of detainees with a focus on "depression, delusional behaviors, manifestations of stress," and "what are their buttons."<sup>37</sup> The interrogators are trained that this BSCT staff will assist them with "obtaining more accurate intelligence information, knowing how to gain better rapport with detainees, *and also knowing when to push or not push harder in the pursuit of intelligence information.*"<sup>38</sup>

One means of carrying out this charge was to bring in Guantánamo BSCT psychologists and others familiar with techniques used to train American soldiers to resist harsh interrogation tactics—like stress positions, isolation, sleep deprivation, threats, sensory deprivation and overload, temperature extremes, and many forms of humiliation—in a program called Survival, Evasion, Resistance and Escape ("SERE").<sup>39</sup> They, in turn, transformed those methods into

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<sup>35</sup> Miles, *supra* note 22, at 2.

<sup>36</sup> SURGEON GENERAL REPORT, *supra* note 29, at 18-12, 18-13.

<sup>37</sup> *Id.* at 19-7.

<sup>38</sup> *Id.* (emphasis added).

<sup>39</sup> See Mark Benjamin, *Torture Teachers*, SALON.COM, June 29, 2006, <http://www.salon.com/news/feature/2006/06/29/torture/index.html>; Jane Mayer, *The Experiment*, NEW YORKER, July 11-18, 2005, available at [http://www.newyorker.com/printables/fact/050711fa\\_fact4](http://www.newyorker.com/printables/fact/050711fa_fact4); M. Gregg Bloche & Jonathan H. Marks, *Doctors and Interrogators at Guantánamo Bay*, 353 NEW ENG. J. MED. 6 (2005). The use of these techniques has a long gestation, deriving from Communist practices in Korea and CIA-sponsored experiments in the 1950s. MARGULIES, *supra* note 3, at 120-25; ALFRED MCCOY, A QUESTION OF TORTURE 25-53 (2006); Memorandum from Dep't of Defense, Criminal Investigation Task Force (Deployed), Guantánamo Bay, Cuba, to JTF-GTMO/J2, re: JTF GTMO "SERE" Interrogation SOP



interrogation techniques for terror suspects and had major influence in designing and controlling interrogation strategy. One member of a BSCT interviewed for the Army Surgeon General's report noted having received specific training in SERE techniques.<sup>40</sup> According to the *New York Times*, psychologists also advised the CIA in devising its "enhanced" interrogation techniques, including water-boarding, or feigned drowning.<sup>41</sup> Indeed, because of their familiarity with, and authorization of, these forms of torture, it is entirely possible, even likely, that the participation of BSCT psychologists in the design of interrogation techniques significantly expanded the use of torture and cruel, inhuman, and degrading treatment in the interrogation of terror suspects—and in the infliction of severe or serious mental harm. The full extent of these practices can only be known once there is full disclosure of interrogation plans and practices, including disclosure of available logs of specific interrogations.

The engagement of psychologists and physicians also has had implications for the use of medical and psychological information about detainees for interrogation. The Army Surgeon General's report makes clear that sharing of medical information about detainees was widespread in U.S. detention facilities.<sup>42</sup> Generally, the sharing of information was permissive,<sup>43</sup> but in some cases, it was mandatory.<sup>44</sup> Moreover, the report found that rules for interrogator access to medical records themselves were vague or non-existent. As a result, at three of the Iraq facilities where the highest number of military personnel were questioned for the report—Abu Ghraib, Camp Cropper, and Camp Liberty—between six and seven percent of respondents said that anyone could have access to detainee medical records,

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DTD (Dec. 10 2002), available at <http://www.aclu.org/projects/foiasearch/pdf/DOD045202.pdf>.

<sup>40</sup> See Army Medicine, Assessment Report Interviews (DVD on file with author). Assessment Report Interviews may be ordered at <http://www.armymedicine.army.mil/news/detmedopsrprt/interviews.cfm>.

<sup>41</sup> Douglas Jehl, *Report Warned C.I.A. on Tactics In Interrogation*, N.Y. TIMES, Nov. 9, 2005, at A1. According to the *Washington Post*, psychologists were also involved in designing kidnappings as part of the CIA's rendition program. Dana Priest, *Wrongful Imprisonment: Anatomy of a CIA Mistake; German Citizen Released After Months of "Rendition"*, WASH. POST, Jan. 3, 2007, at A1.

<sup>42</sup> SURGEON GENERAL REPORT, *supra* note 29, at 7-5. The report noted that detainee medical information is to be protected in accordance with applicable law and regulations. *Id.*

<sup>43</sup> See *id.* It notes that "healthcare providers will not be required to verbally provide detainee medical information to intelligence collectors." *Id.*

<sup>44</sup> *Id.* "Medical personnel shall provide interrogators such information as they believe necessary to protect the health and safety of the detainee or to prevent the commission of a crime." *Id.*

and between seven and nine percent said interrogators could have access to them.<sup>45</sup> At Camp Liberty the percentage was even higher.<sup>46</sup> In Afghanistan, six percent of respondents at the Kandahar detention facility said interrogators could have access to records.<sup>47</sup> Too few health professionals were surveyed at Guantánamo to gain an understanding of the practice there, but a report of the International Committee of the Red Cross in mid-2004 found that medical files of detainees were open to interrogators, and that the “apparent integration of access to medical care within the system of coercion” resulted in inmates refusing to seek medical care or cooperate with doctors.<sup>48</sup>

When these three roles began to be disclosed in the media and subjected to stinging critiques in medical journals in the United States and abroad, the Department of Defense, far from restoring traditional domestic and international ethical standards, decided in 2005 to adopt guidelines to explicitly authorize and regularize medical participation in interrogation. These guidelines were revised in 2006 without significant change in the prescribed role for health personnel, except to state a preference for psychologists in BSCTs.<sup>49</sup> The guidelines departed substantially from international ethical standards, including those adopted by the United Nations.<sup>50</sup> They did so especially by effectively exempting health professionals who are participating in intelligence work but not providing clinical care to detainees from the strictures that would otherwise apply, including the twin obligations of beneficence and non-maleficence (i.e., doing no harm). The most recent guidelines explicitly permit participation by health professionals to act as advisers to interrogators so as long as

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<sup>45</sup> SURGEON GENERAL REPORT, *supra* note 29, at 12-2, 12-3.

<sup>46</sup> *Id.* At Tikrit, Mosul, and Camp Bucca, the percentage was somewhat lower. *See id.* at 12-3 and 12-4.

<sup>47</sup> *See id.* at 12-1, 12-2. Respondents at Bagram denied sharing detainee medical records with “anyone” or with interrogators. *Id.*

<sup>48</sup> Neil Lewis, *Red Cross Finds Detainee Abuse at Guantánamo*, N.Y. TIMES, Nov. 30, 2004, at A1, available at <http://www.nytimes.com/2004/11/30/politics/30gitmo.html?pagewanted=1&ei=5088&en=825f1aa04c65241f&ex=1259470800&partner=rssnyt>.

<sup>49</sup> DEP'T OF DEFENSE, INSTRUCTION NUMBER 2310.08E, MEDICAL PROGRAM SUPPORT FOR DETAINEE OPERATIONS (2006), available at [www.dtic.mil/whs/directives/correspdf/231008\\_060606](http://www.dtic.mil/whs/directives/correspdf/231008_060606)

/231008p.pdf; Memorandum from Assistant Secretary of Def. for Health Affairs to the Secretaries of the Military Dep'ts et al., Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States (June 3, 2005).

<sup>50</sup> Leonard S. Rubenstein et al., *Coercive US Interrogation Policies: A Challenge to Medical Ethics*, 294 JAMA 1544, 1545 (2005); *see also* M. Gregg Bloche & Jonathan H. Marks, *When Doctors Go to War*, 352 NEW ENG. J. MED. 1, 3 (2005).

they are insulated from providing clinical care to detainees. The BSCTs are also permitted to perform psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees, and based on such assessments, advise interrogators on strategies and methods that are based on that particularized knowledge. The guidelines also permit the use of medical records for intelligence, law enforcement, and national security purposes, subject only to pro forma reporting and approval requirements.

What is the appropriate response of the medical and psychological community, as well as the larger society, to the role of doctors, psychologists, and other health professionals as enablers and facilitators of torture and cruel treatment? Their first obligation, it seems to me, is to condemn the techniques used as the devastatingly harmful infringements on human dignity that they are. Professionals profoundly concerned with health and well-being have an obligation to speak up. Two years after the Abu Ghraib photos brought prisoner abuse to everyone's attention, professional associations offered only general condemnations of torture and said little about the terrible harms being inflicted.<sup>51</sup> Recently, however, some associations found a voice. As Congress debated the military commission bills in late 2006, the presidents of the American Psychiatric Association and American Psychological Association, along with others, condemned the brutality of "enhanced interrogation methods" reportedly used by the CIA.<sup>52</sup> They went on to say that "prolonged sleep deprivation, induced hypothermia, stress positions, shaking, sensory deprivation and overload, and possibly water-boarding . . . among other reported techniques . . . can have a devastating impact on the victim's physical and mental health."<sup>53</sup>

The second responsibility, both of the professions and the larger society, is to resist participation by medical personnel in interrogation or in any effort to break detainees.<sup>54</sup> While this may seem self-

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<sup>51</sup> See MILES, *supra* note 1, at 119–39. The American College of Physicians, which is an association of specialists in internal medicine, was a notable exception.

<sup>52</sup> See Press Release, Physicians for Human Rights, *PHR and Seven Leading Health Professionals Call for Prohibition of Abusive CIA Interrogation Tactics in Detainee Treatment and Trial Bill; Congress Must Not Cede Interpretation of Geneva Conventions to President* (Sept. 22, 2006), available at <http://www.physiciansforhumanrights.org/library/news-2006-09-22.html>.

<sup>53</sup> *Id.*

<sup>54</sup> This includes participation in breaking hunger strikes. See George J. Annas, *Hunger Strikers at Guantánamo—Medical Ethics and Human Rights in a “Legal Black*

evident, it is a more contentious question than it first appears. At the extreme, some ethicists, building on the recognition that health professionals sometimes appropriately subordinate duties to individuals to some legitimate social purpose,<sup>55</sup> argue for balancing the traditional ethical duty to do no harm against a purported role in protecting national security—even at the expense of human rights.<sup>56</sup> This position is untenable not only because it would implicate health professionals directly in facilitating torture that governments themselves are bound by law to prevent, even in national emergencies, but also because it would require them to engage in decisions about how to balance national security interests against the health and rights of the individual—decisions they are in no position to make.<sup>57</sup>

An alternative, and more sound, approach is to ground the responsibilities of health professionals in human rights law, since health professionals have an obligation not to become complicit in, much less facilitate, human rights violations committed by states.<sup>58</sup> There are, however, two quite different variants of this position. What may be called the formal approach is to specify that health professionals can participate in interrogation so long as they adhere to the requirements of human rights law prohibiting torture or cruel, inhuman, or degrading treatment or punishment.<sup>59</sup> This is the position of the American Psychological Association, which like medical organizations, has embraced the ethical commitment to do no harm.<sup>60</sup> Accordingly, the American Psychological Association adopted recom-

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*Hole*, 355 NEW ENG. J. MED. 1377 (2006); see also World Medical Association Declaration on Hunger Strikers (2006), available at <http://www.wma.net/e/policy/h31.htm>.

<sup>55</sup> M. Gregg Bloche, *Caretakers and Collaborators*, 10 CAMBRIDGE Q. OF HEALTHCARE ETHICS 275 (2001); M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268 (1999).

<sup>56</sup> Michael Gross, *Bioethics and Armed Conflict: Mapping the Moral Dimensions of Medicine and War*, 34 HASTINGS CTR. REPORT No. 6, 22 (2004).

<sup>57</sup> See Leslie London, et al., *Dual Loyalty Among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict*, 15 CAMBRIDGE Q. OF HEALTHCARE ETHICS 381 (2006); Jonathan H. Marks, *Doctors of Interrogation*, 35 HASTINGS CTR. REPORT No 4 (2005).

<sup>58</sup> London, *supra* note 58; Marks, *supra* note 58; see Physicians for Human Rights and University of Cape Town Health Sciences Centre, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* (2003), available at <http://www.physiciansforhumanrights.org/library/report-dualloyalty-2006.html> [hereinafter Physicians for Human Rights].

<sup>59</sup> See, e.g., AM. PSYCHOL. ASS'N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION'S PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY (June 2005), available at <http://www.apa.org/releases/PENSTaskForceReportFinal.pdf>.

<sup>60</sup> See *id.*

mendations of a task force on ethics and national security that permitted the participation of psychologists in interrogation, and later adopted strong human rights principles for psychologists to follow.<sup>61</sup> Under this view, psychologists may design interrogation techniques, assess individuals for interrogation with the goal of devising the most effective methods of eliciting information from them, advise interrogators about both the individual and the techniques, observe interrogations, and further advise interrogators as the interrogation moves forward.<sup>62</sup> They may be an integral part of the interrogation team—so long as they take care not to violate the individual's human rights. Advancing this position, the American Psychological Association's then-president (and my fellow panelist), Dr. Gerald Koocher, criticized the view of those who express "dismay that psychologists participate in coercive interviews or interrogation at all."<sup>63</sup> Rather, he argued, while human rights must be respected, "[w]e must also respect the legitimate roles of psychologists who participate in interrogation legally and appropriately in an effort to assure our safety."<sup>64</sup>

While this argument has surface appeal in relying firmly on human rights principles, it is problematic in taking little account of the context or realities of interrogation, especially in national security interrogations that take place in isolated settings where detainees lack access to the courts or legal representation, and where there is no mechanism at all to protect them from violations of rights. At a minimum, allowing participation but requiring disengagement if human rights violations are taking place, requires the health professional to determine what practices, alone or in combination, amount to human rights violations, and to do so in an environment in which the government has a record of adopting very narrow definitions of torture and cruel treatment. It also requires health professionals to try to distinguish between the particular techniques used in interrogation and the conditions of confinement that in some cases have been designed to, and indeed have contributed to, the breaking down of detainees in violation of their human rights.<sup>65</sup> Thus, even determining when interrogation is in violation of human rights stan-

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<sup>61</sup> See *id.*; AM. PSYCHOL. ASS'N, RESOLUTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN, AND DEGRADING TREATMENT OR PUNISHMENT (Aug. 9, 2006), available at <http://www.apa.org/governance/resolutions/notortureres.html>.

<sup>62</sup> See AM. PSYCHOL. ASS'N REPORT, *supra* note 60.

<sup>63</sup> Gerald Koocher, *Valued and Varied Roles*, 37 APA MONITOR No. 7 (2006), available at <http://www.apa.org/monitor/julaug06/pc.html>.

<sup>64</sup> *Id.*

<sup>65</sup> See Lewis, *supra* note 49.

dards may be well nigh impossible in the context in which the decisions have to be made.

Even more significant, the environment in which the health professional must make the decision is fraught with pressures and conflicts of interest. As former American Psychological Association President Philip Zimbardo has written, the premise that psychologists (or other health professionals) can make distinctions between permissible and impermissible interrogation, with full power to confront, challenge, and expose unethical practices, ignores the fact that the professionals are part of an operational team, who are

susceptible to normative pressures to conform to the emerging standards of that group. They cannot make readily informed ethical decisions because they do not have full knowledge of how their personal contributions are being used in secret or classified missions. Their judgments and decisions may be made under conditions of uncertainty, and may include high stress. Moreover, definitions of basic terms are not constant, but shifting, so it becomes difficult or impossible to make a fully informed ethical judgment about any specific aspect of one's functions.<sup>66</sup>

Zimbardo also identifies the tremendous pressure on participants to be "team players" in obtaining actionable intelligence, and hence not to question procedures and tactics being used.<sup>67</sup> Questioning requests to participate in interrogations that may violate human rights may jeopardize professionals' own career advancement goals. Given these factors, Zimbardo concludes, "[e]ven intelligent, well-meaning and moral psychologists can be seduced into engaging in behaviors that they would ordinarily deem unacceptable once they get enmeshed in situationally defined roles and adopt new situated identities."<sup>68</sup>

Finally, despite its formal attractiveness, whether a technique violates human rights may not be an adequate standard for assessing whether health professionals should participate in the interrogation process given the nature of that process and their ethical commitments. As noted above, health professionals do sometimes subordinate the interests of patients to important social purposes,<sup>69</sup> and these

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<sup>66</sup> Philip Zimbardo, *Commentary on Report of the American Psychological Association's Presidential Task Force: On Psychological Ethics and National Security* (PENS report), July 19, 2006 (unpublished, on file with the author); see also Robert Lifton, *Doctors and Torture*, 351 NEW ENG. J. MED. 415 (2004); Bloche & Marks, *supra* note 40.

<sup>67</sup> Zimbardo, *supra* note 67.

<sup>68</sup> *Id.*

<sup>69</sup> See Bloche, *Caretakers and Collaborators*, *supra* note 56; Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, *supra* note 56.

purposes may include breaches of confidentiality to protect innocent third parties, the need to control epidemic disease, and other purposes.<sup>70</sup> The consequences of loyalty to social purposes rather than to the patient may be to create legal jeopardy or violate privacy. But there is a significant difference between the abandonment of the patient's interests, as important as they may be, and the direct infliction of physical harm or psychological stress that is the inevitable consequence of any national security interrogation. Interrogation for intelligence purposes is inevitably a deliberate effort to create anxiety, severe discomfort, pain, or stress in the interest of forcing disclosure of information. Thus, it is unlike any of the kinds of harms that often befall an individual when advancing legitimate state interests over those of the individual. This does not mean that interrogation is itself illegitimate, for while interrogators are not bound to do no harm, health professionals are. Just as in states where the death penalty is legal and seen as morally permissible, physicians are ethically bound not to participate.<sup>71</sup>

Accordingly, only a bright line rule against any participation by health professionals in the interrogation of an individual will be effective in preserving ethical standards, protecting the integrity of the profession, and, just as important, assuring the society at large that the health professions are acting in accordance with moral expectations. The World Medical Association has recently taken this stance, adopting an amendment to its Declaration of Tokyo that provides: "The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals."<sup>72</sup> The American Psychiatric Association<sup>73</sup>

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<sup>70</sup> See Bloche, *Caretakers and Collaborators*, *supra* note 56; Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, *supra* note 56.; Physicians for Human Rights, *supra* note 59, at 51–52.

<sup>71</sup> AM. MED. ASS'N, COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, OPINION E-2.06, CAPITAL PUNISHMENT (Aug. 15, 2005), *available at* <http://www.ama-assn.org/ama/pub/category/8419.html>.

<sup>72</sup> World Med. Ass'n, *Declaration of Tokyo, Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* (as amended May, 2006), *available at* <http://www.wma.net/e/policy/c18.htm>.

<sup>73</sup> The Association adopted a resolution that provides as follows:

No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psy-

and American Medical Association<sup>74</sup> have adopted a similar stance against participation in individual interrogations. In its role of setting standards for military and intelligence operations, Congress, the Department of Defense, the CIA, and other agencies should follow suit and remove health professionals, no matter their assigned role, from aiding in the interrogation of detainees.

In an era when physicians, psychologists and health professionals play many social roles beyond the provision of clinical care, where an ethical stance can be compromised by demands of managed care entities and pressures from pharmaceutical companies, and in an atmosphere where obtaining real-time intelligence about terrorism is claimed to trump any other concerns, the obligation to do no harm may appear quaint. But just as then-White House Counsel Alberto Gonzales's dismissal of elements of the Geneva Conventions as quaint led to systematic prisoner abuse, abandoning this long-held obligation would lead only to corruption of the role of the professions and an increase in the horrors inflicted on detainees. Nonparticipation of health professionals in the interrogation of detainees should be an ethical commitment of the professions and a core element of national policy on human intelligence gathering.

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chiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.

AM. PSYCHIATRIC ASS'N, PSYCHIATRIC PARTICIPATION IN INTERROGATION OF DETAINEES, POSITION STATEMENT (May 2006), *available at* [www.psych.org/edu/other\\_res/lib\\_archives/archives/200601.pdf](http://www.psych.org/edu/other_res/lib_archives/archives/200601.pdf).

<sup>74</sup> The resolution provides that "[p]hysicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession." AM. MED. ASS'N, COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, 10-A-06: PHYSICIAN PARTICIPATION IN INTERROGATION (Res. 1, I-05), *available at* [http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja\\_recs\\_10a06.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_10a06.pdf). It also prohibits monitoring interrogations and allows general training for interrogation purposes. *Id.*