

ETHICS ABANDONED

Medical Professionalism
and Detainee Abuse
in the War on Terror



Task Force Report

ETHICS ABANDONED:

*Medical Professionalism
and Detainee Abuse
in the “War on Terror”*

*A task force report funded
by IMAP/OSF*

November 2013

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THE INSTITUTE ON MEDICINE AS A PROFESSION (IMAP) aims to make medical professionalism a field and a force. It promotes this mission through research and policy initiatives. Four key values underlie medical professionalism: physicians and the health care system must be committed to (1) altruism and promotion of patients' best interests, (2) effective physician self-regulation, (3) maintenance of technical competence, and (4) physician civic engagement to promote patient and societal well-being.

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Executive Summary

THE 9/11 TERRORIST ATTACKS on the United States resulted in U.S. government-approved harsh treatment and torture of detainees suspected of having information about terrorism.¹ Military and intelligence-agency physicians and other health professionals, particularly psychologists, became involved in the design and administration of that harsh treatment and torture—in clear conflict with established international and national professional principles and laws.²

In 2010, the Institute on Medicine as a Profession (IMAP) and the Open Society Foundations convened the Task Force on Preserving Medical Professionalism in National Security Detention Centers (Task Force) to examine what is known about the involvement of health professionals in infliction of torture or cruel, inhuman, or degrading treatment of detainees in U.S. custody and how such deviation from professional standards and ethically proper conduct occurred, including actions that were taken by the U.S. Department of Defense (DoD) and the CIA to direct this conduct.

The Task Force met regularly between December 2009 and January 2012. Its members authored and reviewed chapters and policy proposals for the group to consider. This report contains the Task Force's analyses, findings, and recommendations. The report is based on information from unclassified, publicly available information. Where gaps in knowledge exist, we note that information is missing and discuss its importance and its potential impact on the issue assessed, as well as the value of further investigation. In a few instances, a member of the Task Force had personal knowledge of facts discussed, but consistent with an approach that relied on the public record, the report is not based on information obtained by any of its members in another capacity. Additionally, because of the professional roles they play, some members of the Task Force may have a personal stake in the report's findings and conclusions; in such instances, we disclose that fact in the discussion. The Task Force sought consensus on findings and

recommendations. Members agreed to approve the final product, however, even when they did not agree with every statement and recommendation.

A note on the terminology used in this report: When a document refers to a specific category of medical personnel (e.g., physician or psychologist), this report refers to that individual using the same term. In many of the documents, however, no specific occupation is identified. In such cases, we use more general terminology, either “health professional,” where the context is clear that it refers to someone holding a professional license, or “medical personnel,” which includes all occupations in the health field, including physicians, psychologists, registered nurses, nurse practitioners, physician assistants, corpsmen (U.S. Navy or Marine-trained enlisted medical personnel), medics (U.S. Army-enlisted medical personnel), and technicians. In CIA documents, “medical officer” is frequently used. According to current position descriptions on the CIA’s website, a medical officer is a physician,^{2 3} but the CIA’s Office of Medical Services (OMS) guidelines on medical support for interrogation, which are discussed extensively in this report, refer to physician assistants as medical officers as well,⁴ so the Task Force does not assume that a CIA medical officer involved in interrogation activities is a physician unless the document so specifies.

One other note on terminology: In the text, we refer to people in custody as “detainees” because this has become the common way to refer to them in the media and in reports. The Task Force recognizes, however, that this designation stems from the decision of President Bush to deny prisoner-of-war status to them. By using the term detainee, the Task Force does not convey endorsement of this decision. The recommendations use the word “prisoner” as it is forward-looking.

The Task Force has determined that actions taken by the U.S. government immediately following 9/11 included three key elements affecting the role of health professionals in detention centers:

1. The declaration that as part of a “war on terror,” individuals captured and detained in Afghanistan, Pakistan, and elsewhere were “unlawful combatants” who did not qualify as prisoners of war under the Geneva Conventions. Additionally, the U.S. Department of Justice approved of interrogation methods recognized domestically and internationally as constituting torture or cruel, inhuman, or degrading treatment.
2. The DoD and CIA’s development of internal mechanisms to direct the participation of military and intelligence-agency physicians and psychologists in abusive interrogation and breaking of hunger strikes. Although the involvement of health professionals in human rights

violations against detainees progressed differently in the military and the CIA, both facilitated that involvement in similar ways, including undermining health professionals’ allegiances to established principles of professional ethics and conduct through reinterpretation of those principles.

3. The secrecy surrounding detention policies that prevailed until 2004-2005, when leaked documents began to reveal those policies. Secrecy allowed the unlawful and unethical interrogation and mistreatment of detainees to proceed unfettered by established ethical principles and standards of conduct as well as societal, professional, and nongovernmental commentary and legal review.

These key elements, as well as the Task Force’s recommendations for remedying the participation of health professionals in detainee torture or cruel, inhuman, or degrading treatment, are summarized below and addressed in detail in the body of this report.

The development and use of torture and cruel, inhuman, or degrading treatment in U.S. detention centers

The origins of torture and cruel, inhuman, and degrading treatment of detainees are now well documented through released DoD and CIA documents and congressional reports, as well as independent investigations by journalists and human rights organizations.⁵

Immediately after 9/11, the United States took captives in Afghanistan and elsewhere. Those detained by the U.S. military, numbering several hundred at first and thousands later, were held in Afghanistan, then at Guantánamo Bay starting in January 2002, and then in Iraq after the U.S. invasion in 2003. Other U.S. captives, through a process of “extraordinary rendition,” were secretly transferred to third countries, where it was known that torture was used during interrogation. The CIA had its own captives, approximately 100 in number, identified as “high-value” detainees, who were kept in secret CIA-run “black site” facilities for interrogation. What happened at those sites remains classified, except for detainee accounts reported by the International Committee of the Red Cross (ICRC), as well as Justice Department legal opinions and a CIA Inspector General’s report. The CIA was also involved to an unknown extent in interrogations of detainees at military facilities.

The publicly stated goal of interrogations at U.S. detention facilities was to obtain information that would allow the United States to identify and stop potential terrorist strikes and capture additional terrorists. Traditional guidelines for interrogation used by the FBI and the military eschewed and indeed prohibited methods that were in violation of the Geneva Conventions and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment, treaties that the United States, as a party, is bound to follow. Officials at the highest levels of the government rejected these guidelines, however, stating that they believed traditional methods of interrogation were too time-consuming to prevent feared imminent attacks. As a result, almost immediately after 9/11, the U.S. government adopted abusive methods of interrogation.

United States agents subjected the first detainees taken into custody in Afghanistan in late 2001, held principally at detention facilities at Bagram Air Base and in Kandahar, to beatings, exposure to extreme cold, physical suspensions by chains, slamming into walls, sleep deprivation, constant light, and forced nakedness and others forms of humiliating and degrading treatment.⁶

Although the interrogation methods initially used in Afghanistan appear to have been ad hoc, a theory of interrogation soon emerged that was based on inducing fear, anxiety, depression, cognitive dislocation, and personality disintegration in detainees to break their resistance against yielding information. Based on this theory, U.S. agents developed new interrogation methods designed to bring about “debility, dependency and dread.”⁷ The OMS summarized the approach as seeking to “psychologically ‘dislocate’ the detainee, maximize feelings of vulnerability, and reduce or eliminate the will to resist our efforts to obtain critical intelligence.”⁸

THE DEVELOPMENT OF CIA INTERROGATION METHODS

With early direction from the CIA, the new interrogation methods were developed by interrogators and psychologists from techniques used in the pre-9/11 Survival, Evasion, Resistance, Escape (SERE) program for training U.S. armed services personnel to resist coercive interrogation and mistreatment if captured. The interrogators and health professionals transformed training methods used to resist torture into abusive methods of interrogation to be used on detainees.⁹

At the same time, Bush administration officials laid the legal groundwork for a policy that would abandon restrictions on torture and cruel, inhuman, or degrading treatment imposed by treaty obligations and U.S. criminal law. Early in 2002, the White House counsel declared that the Geneva Conventions did not apply to detainees at Guantanamo.

By the summer of 2002, a secret memorandum from the Justice Department’s Office of Legal Counsel, issued in response to a CIA request, claimed that an initial core set of 10 “enhanced” methods could be used legally as part of the interrogation program designed for Abu Zubaydah, a designated high-value detainee. The memorandum restricted the definition of severe mental or physical pain or suffering in a manner that permitted draconian interrogation methods, including attention-grasping (grasping a detainee with both hands and drawing him toward the interrogator), throwing a detainee repeatedly against a wall, facial holds (forcibly holding the head immobile), facial slaps, cramped confinement, wall-standing (forcing a detainee to support his weight on his fingers against a wall), stress positions, sleep deprivation, use of insects, and waterboarding. The Justice Department based its judgments on information provided by the CIA and the DoD, stating that those judgments were founded on experiences with the less harsh SERE training of U.S. service personnel as well as on consultation with outside psychologists.

The Justice Department memorandum stated that health professionals were consulted in the development of “enhanced interrogation” techniques and that “a medical expert with SERE experience” would be present during certain interrogations and “the procedures would be stopped if deemed medically necessary to prevent severe.. .harm.. .”¹⁰ Detainee accounts reported by the ICRC stated that medical personnel—whose specific professions were not revealed to the detainees—were present during CIA interrogations and occasionally intervened.

Over time, the role of medical personnel in CIA interrogations expanded. In 2003, the OMS drafted a first set of “medical guidelines” for interrogation that, while heavily redacted in the publicly released version, described a policy role for the OMS that entailed reviewing and approving the use of enhanced interrogation methods. The review included assessing the potential harms of enhanced interrogation methods and placing limits on their use. The OMS advised limits such as stopping exposure to cold just at the point where hypothermia would likely set in, stopping loud noise before permanent hearing loss would occur, and restricting the use of stress positions to a maximum of 48 hours. The OMS guidelines also described an oversight role for medical personnel during interrogations; they would be present to ensure those interrogations would not cause serious or permanent harm. In the case of waterboarding, the guidelines advised keeping resuscitation equipment and supplies for an emergency tracheotomy on hand. The guidelines advised that an unresponsive subject must be righted immediately and a thrust just below the breastbone administered by the interrogator. The guidelines further stated: “If this fails to restore normal breathing, aggressive medical intervention is required. Any subject who has reached this

degree of compromise is not considered an appropriate candidate for the waterboard, and the physician on the scene cannot concur in the further use of the waterboard without C/OMS consultation and approval.”¹¹

In 2005, the Department of Justice issued a memorandum on the legality of 14 interrogation techniques—expanded from the initial core set of 10—that was based on CIA-described experiences with interrogations of detainees between 2002 and 2005.¹² The descriptions and their differences from the 2002 memorandum, which cites SERE descriptions, are particularly revealing since the 2005 memorandum includes accounts of the methods actually used on detainees rather than those employed in the SERE training program.

The 2002 memorandum described sleep deprivation as keeping prisoners awake for no more than 48 hours. If a detainee fell asleep during that time, he was awakened. The 2005 memorandum described periods of sleep deprivation of up to 180 continuous hours—more than a week—that could be followed by 8 hours of sleep and then repeated. Detainees were kept awake by being shackled in a standing position, hands to the ceiling and feet to the floor, fed by detention personnel and diapered so that nothing interfered with the standing position. The memorandum acknowledged that the position produced swelling of the legs. The detainees were nude. Ambient temperatures during sleep deprivation were not described, but nudity was described in the 2005 memorandum as a separate and often concurrent interrogation technique that was accompanied by air-conditioned ambient temperatures often as low as 68 degrees and on occasions as low as 64 degrees.

Water-dousing was not included in the 2002 memorandum, but the 2005 memorandum described nude detainees who were kept in environments with temperatures as low as 64 degrees and doused with cold water of 41 to 59 degrees that was poured from containers or sprayed from hoses. Aside from producing extreme discomfort, such a procedure risked producing hypothermia, a dangerous and potentially deadly drop in body temperature.

Waterboarding, described only briefly in 2002, was meant to induce the feeling and threat of imminent death. In the 2005 memorandum, waterboarding was described as causing the sensation of drowning and carrying risks of aspiration, airway blockage, and death from asphyxiation.

Other methods of enhanced interrogation reviewed for the CIA by the Department of Justice in 2005 included (a) stress positions consisting of sitting, kneeling, and leaning in awkward positions for long periods of time; (b) standing facing a wall 4-5 feet away with arms outstretched, fingers resting on the wall to support body weight, with the detainee not permitted to reposition hands or feet; (c) cramped confinement in a small space that in some cases

forced the detainee to sit painfully for as many as 18 hours a day; (d) abdominal and facial slaps; (e) forcibly holding the head immobile; (f) pushing and slamming the detainee against walls; (g) grabbing the neck area during questioning; and (h) bland, low calorie diets.

The Department of Justice pronounced all of these techniques to be legal under U.S. law. Interrogation methods used but not reviewed by the Justice Department for legality included threatening detainees and their families, cocking a gun next to a detainee’s head, and isolation. In addition, the CIA imposed conditions of confinement that contributed to the overall intimidation, coercion, degradation, and suffering of detainees. Detainees were also subjected to beatings and sexual and cultural humiliations.

The 2005 Justice Department memorandum relied heavily on purported medical opinion, supplied by the CIA, to claim that the enhanced interrogation methods would not inflict severe mental or physical pain or suffering, as defined by the memorandum, on the detainees. The Task Force finds, however, that there was no basis in either clinical experience or research studies to substantiate these opinions. Indeed, the OMS guidelines discussing each method are bereft of citations to the extensive medical literature on torture.

THE U.S. MILITARY AND THE INTRODUCTION OF CIA METHODS OF INTERROGATION

The evolution of abusive interrogation methods in the U.S. military took a more convoluted course than in the CIA because of significant internal opposition to the techniques. Nevertheless, under pressure from the civilian leadership, by the end of 2002 the military implemented SERE-based interrogation strategies at Guantánamo, and later in Iraq and Afghanistan as well.

In early 2002, the DoD established the first of its Behavioral Science Consultation Teams (BSCTs), which typically but not always consisted of a psychologist, a psychiatrist (a physician specializing in mental health), and a mental health technician (a non-physician, armed services-trained enlisted person), that played a key role in developing the SERE-based interrogation methods. In late 2002, the first BSCT, deployed at Guantánamo, recommended the use of sleep and sensory deprivation, exposure to extremes of noise and temperatures, stress positions, and other enhanced methods (waterboarding was not included). The BSCT recommendations were transmitted up the chain of command and largely approved by the Secretary of Defense. Implementation began in November 2002 during a 54-day interrogation of Mohammed al-Qahtani, who was alleged to have been a part of the 9/11 hijacking group but was denied entry to the United States. The U.S. military deprived him of sleep through the use of

loud noise, yelling, and forced standing; subjected him to multiple forms of sexual and religious humiliation; doused him with cold water (including when he was naked); strapped him into painful stress positions; and terrified him with a dog. A BSCT psychologist consulted on the interrogation and a BSCT psychiatrist witnessed part of it.¹³

Although internal controversy had led to further reviews of interrogation methods in early 2003, the existing evidence shows that sleep deprivation, isolation, sensory deprivation, bombardment with loud noise, stress positions, and exploitation of phobias, among other methods, were all used at Guantánamo. After the U.S.-led invasion of Iraq in March 2003, these methods were used there as well. Although no BSCT was established in Iraq until after the Abu Ghraib scandal broke in April 2004 (with the exception of one brief period), the use of torture was pervasive. There is evidence that detainees at Abu Ghraib and elsewhere in Iraq were also subjected to abuses beyond the authorized interrogation methods, including beatings and sexual assaults.¹⁴

BSCTs also advised intelligence and detention officials on conditions of confinement that would enhance capture shock, dislocate expectations, foster dependence, and support exploitation of detainees to advance intelligence gathering. BSCT recommendations included using fans and generators to create white noise as a form of psychological pressure; restricting some detainees to no more than four hours of sleep a day; depriving them of basic living items—officially named “comfort items”—such as sheets, blankets, mattresses, and washcloths; and controlling their access to the Koran.

The BSCTs’ core role, however, was to assess detainees’ vulnerabilities through psychological evaluations and review of their medical records, and advise interrogators on how to exploit those vulnerabilities to gain intelligence. Members of the BSCTs advised on interrogation strategies before and during interrogations, including advising interrogators on when to increase the harshness of the interrogation. Although the records of interrogations remain classified, there is evidence that BSCTs urged interrogators to increase the intensity of interrogation.

Over time, as discussed below, both military and CIA policies adopted language that described the function of psychologists and physicians as being there to protect detainees from harm. By 2004, the military had begun to refer to BSCT members as “safety officers” who would protect detainees by assessing the extent of harm being done to them and preventing what the DoD referred to as “behavioral drift” by interrogators. However, the military was simultaneously directing BSCT members to advise interrogators in exploiting detainee vulnerabilities, amounting to a problematic contradiction in roles that remains

in effect today. Similarly, the CIA’s OMS guidelines stated that one role of medical officers was to protect detainees from severe harm, yet they were to be present when torture was being inflicted.

MEDICAL CARE FOR DETAINEES

In the period 2002-2004, medical care for detainees was chaotic, especially in Afghanistan and Iraq, with little attention to maintaining and storing medical records, inadequate supplies for treatment, and lack of clarity on applicable standards of care.¹⁵

At Guantánamo, there were early efforts to organize medical care, although it took more than two years before sufficient protocols were established. To the Task Force’s knowledge, medical personnel at Guantánamo providing clinical care were not directly engaged in interrogation support activities and in some cases were highly insulated from it. The DoD established a modern hospital and made specialists available. In one study, a sizable minority of released detainees expressed satisfaction with the quality of clinical care. Many detainees, however, complained about it, especially that the quality of clinical care was compromised by the conditions of their detention and their lack of trust in all medical personnel because of the role of the BSCTs in interrogation. Some detainees did not seek care out of reasonable fear that their medical information would be passed on to interrogators. Moreover, some medical practices were highly questionable, including the unexplained use of the anti-malarial drug mefloquine, which may have significant mental side effects.

Mental health care appears to have been especially deficient. Despite the psychological deterioration of detainees at Guantánamo in 2002 and 2003, evidenced by more than 350 acts of self-harm in a single year, available medical records show no official clinical investigations of the circumstances or causes of the detainees’ suffering. Diagnoses of post-traumatic stress disorder were made by independent medical evaluations arranged by lawyers for detainees. In cases where the connection between abusive practices and psychological deterioration was self-evident, such as the use of isolation leading to severe anxiety, depression, or psychosis, clinicians lacked the authority to change the circumstances of confinement.

In Iraq and Afghanistan, evidence shows that clinical medical personnel were not isolated from interrogations as at Guantánamo; they engaged in various aspects of interrogation as well as other security functions. Physicians reportedly monitored interrogations and psychiatrists signed off on interrogation plans involving sleep deprivation. According to a survey released in 2005 by the Army Surgeon General, in Iraq 10 percent of medical personnel, which

may have included physicians, stated that they had been present in interrogations. In Afghanistan it was even higher—17 percent. It remains unclear what precise roles they played.

Physicians and nurses were in a strong position to identify the physical and mental consequences of torture and cruel, inhuman, or degrading treatment among detainees in their care. All military personnel have a duty to report abuse, but at least through 2004, the military had no policies or procedures for medical personnel reporting of abuse. What is clear, however, is that in Iraq and Afghanistan, as at Guantánamo, there was no policy or guidance regarding medical personnel reporting of abuse.

Even as the use of torture by the military began to decline in 2005 and 2006 when a new DoD interrogation field manual was issued that prohibited the use of many (but not all) highly coercive methods, physicians and nurses became involved in unethical force-feeding and use of restraint chairs in breaking hunger strikes. This subject is discussed below.

Policies that directed health professional participation in torture or cruel, inhuman, or degrading treatment

The activities of medical personnel at the CIA and in the military were largely a result of policies designed, contrary to professional ethical requirements, to employ those personnel in advancing interrogation.

Although the CIA no longer detains terrorist suspects, many of the DoD policies and rules governing health professionals in detention centers remain in place and must be changed if the integrity of health professional practice in the military is to be restored.

The DoD made three key changes in ethical standards and policies to rationalize and facilitate medical and psychological professionals' participation in interrogation. First, contrary to ethical standards adopted by all medical and psychological associations, including standards applicable to forensic practice, it limited the professional duty to not do harm. The duty to avoid or minimize harm, the DoD holds, does not apply to the BSCTs involved in interrogation because they are not involved in clinical treatment. The DoD determined for itself what rules BSCT members should follow and unilaterally deemed those rules ethical. They amounted to no more than adherence to the legal duty of all members of the military not to treat detainees inhumanely. The DoD went so far as classifying physicians and psychologists on BSCTs as

combatants who are not subject to all ethical duties of their profession, even though they are required to hold a professional license.

American and international medical associations have, by contrast, made clear that a physician using professional skills is always a physician subject to the ethical requirements of the profession. The DoD position undercuts the fundamental role of health professionals in society and the duties attached to that role, including non-participation in interrogation on the basis that it is inherently coercive.

The DoD wants its behavioral science consultants to have professional qualifications, including a license for clinical practice in psychology or forensic psychiatry, but then excludes them from the full panoply of ethical norms that govern their professions and that they committed to uphold. The American Psychological Association, while opposing torture, supports the role of psychologists in interrogation, and has rejected the claim that professional obligations differ depending on role. In the Task Force's view, the American Psychological Association incorrectly permits psychologists to balance professional obligations against national security interests and embraces the idea that psychologists can simultaneously and without conflict play the roles of aiding in intelligence gathering and safeguarding the well-being of detainees in interrogation. The American Psychological Association also mistakenly relies on forensic standards of practice to justify these roles, as those standards do not eliminate the duty to avoid or minimize harm and the forensic role does not involve acts that intentionally impose harm.

A second key change adopted by the DoD involved conflating ethical standards for health professionals involved in interrogation with general legal standards. The very purpose of medical ethics is to establish professional norms of practice that extend beyond adherence to the law. Medical ethics recognize the unique role health professionals have in society, having authority and autonomy as well as the duty to advance well-being. Unlike an interrogator, who may create stress for a detainee so long as he or she acts within legal standards, including those prohibiting torture and cruel, inhuman, or degrading treatment, a health professional has an obligation not to participate in acts that deliberately impose pain or suffering on a person. Replacing ethical standards with a legal one—that is, only to refrain from torture and cruel, inhuman, or degrading treatment—eviscerates the ethical standards.

The CIA also replaced medical ethical standards with legal ones, though it did not distinguish, as the military did, between duties of health professionals engaged in clinical care and those supporting interrogation. Instead,

it adopted a standard that required all medical officers to refrain from acts that impose “severe physical or mental pain and suffering,” a phrase borrowed from the legal definition of torture. In other words, the CIA permitted medical officers to engage in any act toward a detainee short of engaging in torture.

The third key change, adopted after criticism of health professionals’ roles in interrogation, was to characterize the DoD’s behavioral science consultants as “safety officers” and to claim that medical personnel in CIA black sites were present to protect detainees from excessive harshness during interrogations. The safety officer description remains in place today within the military. These descriptions rationalized the participation of health professionals in interrogation, and reveal the contradictory functions health professionals have played. The safety officer designation, for example, was accompanied by the responsibility to identify vulnerabilities of detainees and collaborate with interrogators in exploiting them. The DoD has never addressed the contradiction in these roles. Further, medical ethical principles do not permit any role in an individual interrogation, even as a purported safety officer, as mere presence can signal approval of abusive practices so long as the health professional expresses no objection.

In addition, at Guantánamo Bay, policy has allowed interrogators to use medical and psychological information about detainees to exploit their weaknesses in interrogation. In 2004, the ICRC reported that military interrogators were freely accessing detainee medical records. The DoD at first denied the claim and then established instructions (policies issued by civilian authority to govern practices by the military services) allowing such access. In response, medical associations issued standards and statements against the use of prisoners’ medical information, whether from clinical records or otherwise, to gain an advantage in interrogation. The DoD then issued a series of confusing and often contradictory policy revisions from which a new policy appears to have emerged: detainee medical information is authorized to be used for intelligence gathering. Clinicians themselves do not share their records of treatment with interrogators, but BSCTs are permitted to conduct psychological assessments of detainees and share that information with interrogators so long as it is not used in a manner that would result in inhumane treatment, be harmful to the detainee, or violate law.

It remains unclear, however, whether BSCTs can and do access medical treatment records. Policy issued at the highest civilian level of the DoD permits it. There is no legal or regulatory impediment to sharing detainee medical information with interrogators. As described above, detainees knew medical infor-

mation was shared with interrogators, and many declined to seek medical care as a result. The DoD policy on access to medical records is therefore seriously deficient.

Another deficient DoD policy is that on abuse reporting by health professionals. Under widely accepted international standards established in the 1999 Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, commonly known as the Istanbul Protocol, physicians have the responsibility to conduct a thorough physical and mental examination of a prisoner or detainee when torture or cruel, inhuman, or degrading treatment is suspected. The protocol requires physicians to both engage in that examination and make a determination of the likely source of the injury (a summary of clinical guidelines under the protocol is contained in the appendix of this report).

A 2005 report from the Army Surgeon General acknowledged that despite a general obligation of all soldiers to report abuse of detainees, specific requirements for abuse reporting by medical personnel were either not in place or vague and inadequate. Medical personnel were generally not trained in abuse reporting until at least 2004 or 2005, and even then the scope of reporting responsibilities remained unclear. The Surgeon General called for guidance and clarification at every level of command as well as standardized guidance on reporting and processing of claims of abuse. To this day, however, abuse reporting requirements for health personnel working in detention centers remain vague and BSCT training guides do not include abuse reporting. The reporting requirements and training guides do not instruct a clinician who suspects abuse to conduct a medical examination, as required by the Istanbul Protocol, to determine whether torture may have occurred. Indeed they preclude such examinations.

The most fundamental problem with abuse reporting standards, however, was the DoD’s authorization of “enhanced interrogation methods” and other forms of torture in interrogation. Until repealed, the DoD did not consider those methods to be abuse and thus they were not reportable. Military personnel at all levels understood that the methods were approved by military lawyers, likely contributing to the lack of reports of abuse by medical personnel even for the most brutal interrogations.

The Task Force finds that unless changes are made in the standards and policies about abuse reporting and clinical assessments for torture, the potential remains for impedance of reporting of abuses by health professionals.

The DoD recently established an ethics review board for Guantánamo that includes one civilian member. This is a positive development, but insufficient until proper ethical standards are established.

Hunger strikes and forced feeding

Hunger strikes are defined as total fasting with only water ingested for more than 72 hours by a mentally competent, non-suicidal person for the purpose of obtaining an administrative or political goal rather than self-harm. Hunger strikers are generally seeking to address grievances and establish a degree of control over their circumstances of confinement. So long as the individuals drink water, refusal of food usually has few medical consequences until 72 hours have elapsed. In general, it takes 7-8 weeks of refusing food before the hunger strike may become life threatening.

International ethical standards and guidelines for treatment established by the World Medical Association and U.S. national medical practice standards guide both physicians and detention facilities responses to hunger strikes. Physicians have the ethical responsibility to determine if a prisoner's action is indeed a hunger strike; ensure the hunger striking individual's well-being; determine the individual's competence to make informed decisions; counsel the individual regarding the consequences and risks of extended food refusal and the options he or she has; determine whether the individual's decisions are made freely and without coercion; and see to the medical care of the individual during the hunger strike. Recognized ethical standards require physicians to act on behalf of the hunger striker at all times. Physicians must act as medical care providers and counselors to prisoners, helping them make decisions. They must not act as agents for the detention center or any other authority, seeking to persuade hunger strikers to give up a fast or end a protest. Central to the standards is the requirement that physicians should never force-feed competent, non-suicidal, informed hunger strikers.

Guantánamo had its first hunger strike just weeks after it opened in January 2002. The episode ended with an agreement by the authorities to look into grievances. When strikes recurred and became increasingly difficult to resolve, in part because they involved large numbers of detainees, the DoD adopted force-feeding policies on the premise that hunger strikes were dangerous and detainees should not be allowed to kill themselves by such protests. The policies were clearly in violation of established medical standards and principles for dealing with hunger strikers. Involuntary feeding was a command decision, not a medical one.

Through mid-2005, there were only a few instances of involuntary feeding at Guantánamo, and the head of the Joint Medical Command, which is responsible for medical services, told a court that detainees rarely physically resisted it.

Later that year, however, a large coordinated hunger strike, involving as many as 210 detainees, resulted in an escalation of the military response. Physicians, nurses, and possibly other medical personnel began routinely inserting nasogastric tubes through the detainees' noses into their stomachs, a medical procedure done by physicians in civilian circumstances requiring temporary access to the stomach. They administered liquid food through the tube and eventually removed the tube. Detainees who resisted were forcibly restrained and the nasogastric tube was forcibly inserted. As described by detainees, non-physicians sometimes participated in the tube insertions and feedings that at times were exceptionally forceful and traumatic. This force-feeding was very different from the responses to hunger strikes that have occurred in Northern Ireland, Turkey, and elsewhere.

In December 2005, frustrated by their inability to stop the hunger strikes and the time it took to force-feed, Guantánamo authorities took the unprecedented step of introducing special chairs with straps to restrain the detainee's hands, feet, forehead, and chest for the purpose of force-feeding through nasogastric tubes. During the procedure, which is still in use today, medical personnel feed detainees in restraint chairs and then keep them there for 60-90 minutes.

In 2004 and 2005, as the use of force-feeding and, later, restraint chairs became known, medical associations protested vigorously. The World Medical Association, which was in the process of strengthening its policy on hunger strikes, made clear that force-feeding a competent hunger striker is always unethical. Nevertheless, in 2006 the DoD issued an instruction that characterized hunger strikes as attempted suicides rather than protests,¹⁶ contrary to the observation of many of its own officers and medical staff that hunger strikes were indeed protests and not attempts at self-harm. The DoD rationalized force-feeding as necessary to save lives. It restated the authority and responsibility of the senior detention facility officer to carry out the directive. The Task Force finds the claim of saving lives not credible: the available evidence suggests that force-feeding has been used commonly, not just in rare instances where a detainee's life was threatened.

The DoD also claimed that its force-feeding policies follow the procedures of the U.S. Bureau of Prisons, yet that agency does not use restraint chairs and has very strict rules on the use of physical restraints on prisoners, including prohibiting the use of four-point restraints without specific approval of the warden as the only means to maintain control over an inmate. The Bureau of Prisons also grants detainees access to counsel and to the courts, does not engage in force-feeding as a tactic to break political protests, and requires that the response

to political protests be in accord with accepted medical practice. Physicians sent to Guantánamo are screened by the DoD prior to deployment to ensure that they do not object to force-feeding.

In 2009, a federal court determined that force-feeding in restraint chairs had become standard policy at Guantánamo. Feedings in restraint chairs were generally administered daily as long as the hunger strike continued, in some cases for months or years. For some detainees, the use of restraint chairs and force-feeding was painful and constituted a violent assault; some have suffered long-term deleterious consequences as a result. The Task Force concludes that the practice is used as a punitive measure to induce prisoners to give up their protests.

It is clear to the Task Force that the policy of force-feeding deviates from standard, accepted medical and ethical treatment of hunger strikers and, depending on the individual circumstances, amounts to either torture or inhuman and degrading treatment. Military physicians, directed by DoD regulations and detention facility authorities, have participated in force-feeding in violation of their ethical principles and standards of care. The force-feeding policies undercut necessary, ongoing physician-patient relationships and independent medical judgment.

The Task Force has not been able to obtain the current policy on force-feeding at Guantánamo. At the time of this report, hunger strikes continue.

Medical education and attention to ethical principles and conduct in military detention settings

Ethical principles that provide guidance for physicians in difficult and complicated circumstances are particularly relevant for physicians in military detention settings. A litany of international and national ethical principles have direct bearing on physicians dealing with prisoners of war, interrogation, and torture, but they have not been employed to train military physicians in U.S. detention facilities.

The U.S. military's medical school, the Uniformed Services University of the Health Sciences, currently does not have any stated learning objective that directly refers to the role of military physicians in detention settings. The Task Force believes the school should address the ethical questions arising in detention facilities even though only a small number of its students are deployed to detention facilities. After 9/11, the school did develop material on the role of physicians in interrogation, but that material failed to make clear that firm,

unequivocal ethical standards applied. Postgraduate medical residency programs, even those in military medical centers, do not provide separate ethics training other than discussions of issues related to particular patients.

All military physicians receive basic officer training, which provides orientation to military criminal law, courts-martial procedures, aspects of the Uniform Code of Military Justice, the Geneva Conventions, and the U.S. Army field manuals. These materials include prohibitions against mistreatment of prisoners of war, but prior to 2005, military physicians received very little actual training on roles and responsibilities in relation to prisoners and detainees, even on such basic issues as abuse reporting and standards of care. In 2005, the military instituted pre-deployment training specifically for medical personnel who will be engaged in prisoner or detainee care, but the Task Force was unable to access the training materials. The Task Force believes such training should include matters covered by this report, including participation in interrogation, confidentiality and access to medical records, abuse reporting, and appropriate responses to hunger strikes.

The DoD acknowledges that the field of psychological or psychiatric support for interrogation lacks an evidence base or certification procedures for practitioners. Rather than refraining from placing these health professionals in a position where knowledge is lacking but ethical concerns serious, the U.S. Army has created a training course for behavioral science consultants covering various aspects of psychology, law, interrogation, and ethics (as interpreted by DoD). In light of the inadequate knowledge base, the course cannot be considered to meet professional standards.

The role of professional medical and psychological associations in promoting ethical standards

The involvement of military and intelligence-agency physicians and other health professionals in the abusive interrogation and mistreatment of detainees has conflicted with professional ethical principles and standards of conduct that were in place prior to 9/11. Remediation will require acceptance of existing professional ethical standards by the military and the adoption of additional ethical standards by associations that specifically address all aspects of health professional involvement in detention center practices. American physicians and psychologists, through their professional associations, must call for and participate in the remediation.

in the United States, ethical principles for medical practice are produced by the two largest medical associations, the American Medical Association and the American College of Physicians. Other U.S. medical associations, totaling more than 100, adopt those principles or modify them for particular subspecialties. Many of the principles originate from and are in accord with those developed by the World Medical Association, whose members are national medical associations like the American Medical Association. Before 9/11, the World Medical Association, as well as the American Medical Association and American college of Physicians, had well-established ethical principles regarding torture: The World Medical Association set forth principles in 1975 indicating that physicians should not participate in, be present during, monitor, or provide medical information to facilitate torture. The American Medical Association's 1999 ethical principles had similar prohibitions, as did the American college of Physicians' 1995 policy statement.

When the involvement of physicians and health professionals in interrogation and mistreatment of detainees became known, the American Medical Association and American college of Physicians, along with the American Psychiatric Association, responded with protests and refinement of their ethical principles. Between 2006 and 2008, they specifically prohibited direct medical involvement in interrogations and the provision of detainee medical information to interrogators, and imposed duties to report mistreatment.

The American Psychological Association, however, adopted in 2005 the conclusions of its Presidential Task Force on Psychological Ethics and National Security, which reaffirmed the association's prohibition against torture and cruel, inhuman, or degrading treatment, but also stated that psychologists serving in "consultative roles to interrogation and information-gathering processes for national security-related purposes" were engaged in actions consistent with its ethics code. This position was met with severe criticism both within and outside the organization. In 2007, the association identified interrogation methods it considered to be torture, and in 2008, the membership pushed for and passed a referendum affirming that psychologists may not work where persons are held in violation of international law or the U.S. Constitution unless they work for the detainee or for the protection of human rights. Still, the association policy permits psychologists to participate directly in interrogation. The Task Force believes the association should change that stance in keeping with the standards of medical associations that prohibit direct participation in interrogation.

The Task Force holds that medical and psychological associations should play a central role in remediation of the circumstances and policies that directed the participation of military and intelligence health professionals in torture and

cruel, inhuman, or degrading treatment of detainees. Actions should include fostering greater awareness within the health professional community and with the wider public of what happened and why; refining ethical principles to cover all known aspects of health professional participation; professional and public education; fact-finding and investigations wherever helpful; supporting stronger disciplinary action through state health professional licensing boards; and, in the future, when operational standards and policies are in accord with professional ethical principles, taking internal organizational actions against member violators of ethical principles and guidance.

Linking military and intelligence health professionals to civilian accountability mechanisms should be the goal of all concerned—including the military and the CIA. Professional medical associations should be key participants in a system of accountability that also involves the DoD and civilian agencies dealing with credentialing and fitness-to-practice assessments, including medical licensing agencies and specialty certifying boards. Similar mechanisms of accountability should be instituted for psychologists.

Accountability for health professionals through state licensing

Military and intelligence health professionals who are involved in torture or cruel, inhuman, or degrading treatment of detainees should be accountable to the same fitness-to-practice, civilian disciplinary system as all other health professionals. That system includes sanctions related to professional licensure, a process that is under the authority of individual states and exercised through state boards of professional conduct. Ideally, such state proceedings should be part of a system of accountability involving the military or other employing federal agency, state licensing agencies, professional medical associations, and specialty certifying boards.

The military and the CIA should establish policies and procedures in accord with professional medical ethical standards and assess the performance of health professionals using those policies. Violations and judgments against military and intelligence health professionals should result in reviews by civilian-based processes, since military and intelligence physicians and psychologists are, nonetheless, U.S. physicians and psychologists, regardless of the setting in which they render their services.

As of the publication of this report, state licensing and disciplinary boards in Alabama, California, Georgia, Louisiana, New York, Ohio, and Texas have

received—and dismissed—complaints against health professionals for alleged mistreatment of detainees at Guantánamo and secret CIA detention centers. To the knowledge of the Task Force, none of these complaints has led to a formal hearing that then led to a decision holding the individual to account. Many of the complaints were dismissed on procedural grounds. The boards rarely explained the bases for these decisions, but together they suggest an unwillingness of state licensing bodies to address complaints of misconduct within national security agencies or a belief by the boards that they are unable to pursue them. They also reveal procedural and substantive deficiencies in the way state boards approach discipline of health professionals alleged to have been complicit in torture or other forms of cruel, inhuman, or degrading treatment. These practices and procedures contribute to a lack of disciplinary accountability for unethical acts of severe harm on detainees.

States' non-enforcement of ethical obligations comes at a great cost, undermining professional standards, eroding public trust, and undercutting deterrence of future misconduct. Lack of consistent enforcement also compromises the protection of health professionals who face DoD and CIA pressure to violate their ethical obligations. By contrast, disciplinary accountability signals to licensees and those who employ them that the profession and institutions designed to ensure adherence to ethical obligations take violations seriously. Moreover, it empowers health professionals to resist demands by authorities to engage in acts that violate their professional responsibilities and to report abuse when they believe it has occurred.

The Task Force proposes reforms in state policies that would specifically identify health professional abuse of detainees as misconduct under the law and improve the procedures necessary to effectively prosecute that misconduct.

Findings and Recommendations

WE EMPHASIZE HERE AND ELSEWHERE in this report that the Task Force's findings are based on an incomplete record, as many key documents, including interrogation records, medical files, and internal instructions, have not been publicly released.

Finding 1. Information gleaned from official documents and witnesses, investigations conducted by journalists and human rights organizations, and publicly available physical and mental examinations of current prisoners and released prisoners has revealed the systematic use of torture and cruel, inhuman, or degrading treatment against terrorist suspects detained by U.S. authorities outside the United States. Military and intelligence physicians and psychologists participated in these abuses. The record of these practices remains fragmentary, however, and a full and transparent investigation is needed to reveal all that occurred.

Recommendation: The president of the United States should order a comprehensive investigation of U.S. practices in connection with the detention of suspected terrorists following 9/11 and report the results to Congress and the American people. The investigation should include inquiry into the circumstances, roles, and conduct of health professionals in designing, participating in, and enabling torture or cruel, inhuman, or degrading treatment of detainees in interrogation and confinement settings and why there were few if any known reports by health professionals. In addition, the Senate Intelligence Committee should release its report on the role of the CIA in torture after redactions needed to protect legitimate secrets.

- *The president should instruct current military and intelligence personnel with knowledge of the facts, including contract employees, to cooperate substantively with the investigation. Further, the president should compel the testimony of individuals previously employed by or under contract with military or intelligence agencies.*

- *The investigation should include substantive interviews with and medical examinations of detainees released from or still in U.S. custody, subject to their consent. The interviews should include guarantees of no reprisal.*
- *Where supported by the investigation's findings, the report should include an acknowledgment of acts of torture or cruel, inhuman, or degrading treatment committed against detainees in U.S. custody, and the damage done to their health, families, and social relationships.*
- *The investigation should review all relevant CIA and military records, including detainee medical records and interrogation logs.*
- *The president should declassify as much information contained in the investigation's report as possible, except when there are compelling national security reasons for retaining classification. This should include removal of redactions in previously released documents under the same standard.*

Finding 2. The president has issued an executive order prohibiting the use of torture and other forms of cruel, inhuman, or degrading treatment, and has repudiated Justice Department legal memoranda authorizing its use. However, the Army Field Manual on Human Intelligence Collector Operations, which binds both military and CIA interrogators, permits methods of interrogation that are recognized under international law as forms of torture or cruel, inhuman, or degrading treatment. Such methods include sleep deprivation, isolation, and exploitation of fear.

Recommendation: The United States should end authorization of the use of interrogation methods that amount to torture or cruel, inhuman, or degrading treatment or punishment.

- *The president should issue an executive order specifically prohibiting the use of sleep deprivation, isolation, exploitation of fear, and other interrogation methods that violate international standards regarding torture and other forms of cruel, inhuman, and degrading treatment. The Department of Defense (DoD) should revise its Army Field Manual on Human Intelligence Collector Operations in accordance with the new executive order.*
- *The United States should accede to the Optional Protocol to the Convention Against Torture, which requires the creation of an independent domestic monitoring body for the purpose of preventing torture against individuals in custody.*

Finding 3. The DoD and CIA required physicians, psychologists, and other health professionals to act contrary to their professional obligations. These obligations include refraining from harming individuals with whom they interact in their professional capacities, maintaining confidences, being transparent about their professional roles, and exercising independent professional judgment. The agencies inappropriately held health professionals to ethical standards contrary to professional ethical principles. They also equated compliance with professional ethical standards with conformance to the far lower standards of criminal law; excused violations of ethical standards by inappropriately characterizing health professionals engaged in interrogation as “safety officers”; implemented rules that undermined the ethical requirement of confidentiality for detainee medical information; required physicians and nurses to forego proper medical judgment to force-feed competent detainees engaged in hunger strikes; and improperly designated licensed health professionals using professional skills in interrogation as combatants, a status incompatible with their licensing.

Since 2006, the DoD has enacted reforms promoting professionalism in the clinical treatment of prisoners, and it recently instituted a medical advisory committee to review ethics concerns in the treatment of prisoners at Guantánamo, but it continues to uphold policies that undermine standards of professional conduct in the context of interrogation, response to hunger strikes, and reporting abuse.

Recommendation: The DoD and CIA should ensure that health professionals in detention centers adhere to the ethical principles of their professions.

- *The DoD and CIA should adopt standards of conduct for health professionals involved in detainee interaction that conform to those standards of conduct established by the health professions. These standards include the basic duties of all professionals who employ their professional skills, regardless of role, to avoid harm, to uphold transparency and honesty, to protect confidentiality, and to respect detainee autonomy in responding to hunger strikes. The agencies should affirm the duties of health professionals to report coercive and abusive practices to authorities; refrain from conducting, being present during, monitoring, or otherwise participating in interrogations, including developing or evaluating individual interrogation strategies; and refrain from providing medical information to interrogators or advising on conditions of confinement that advance interrogation.*
- *The DoD should no longer classify military health professionals who use their professional skills in their job as combatants. It should rescind all guidelines, instructions, and other policies that explicitly or implicitly state the contrary.*

- *The DoD and CIA should prohibit the use of information obtained from medical or psychological treatment or assessments from being shared directly or indirectly with military or intelligence agency interrogators or used in interrogation. The agencies should rescind all guidelines, instructions, and other policies that explicitly or implicitly state the contrary. Consistent with international and domestic ethical standards, medical examinations to determine whether an individual should not be interrogated or to treat conditions that arise during interrogation would not be affected by this standard.*
- *To ensure reporting abuse by health professionals, the DoD and CIA should establish mechanisms for investigating and reporting abuse that are consistent with international standards.*

Finding 4. In responding to hunger strikes by detainees, the DoD has failed to adhere to the requirements of the World Medical Association's Declaration of Malta, which calls upon physicians to evaluate, support, counsel, and meet the needs of the competent and voluntary hunger striker, including respecting the striker's refusal to eat. The American Medical Association has also taken a strong position against forced feeding of hunger strikers. The DoD has engaged physicians and nurses in the force-feeding of hunger strikers in violation of professional ethical standards. It has also engaged them in using physical restraints in the process of force-feeding, which depending on individual circumstances amounts to either torture or inhuman and degrading treatment. In some cases force-feeding with the use of physical restraints has lasted for months at a time and in a few cases for years. The decision to force-feed is a command decision, thereby preventing physician independence and autonomy. In many cases, officials began force-feedings before the detainee was at any health risk from not eating. The process of force-feeding requires nurses to act in a manner that precludes their using independent judgment and responding to the needs of the detainee subjected to force-feeding.

Recommendation: The DoD should establish policies, procedures, and standards of care that are in keeping with established professional ethical standards regarding detainees engaged in hunger strikes.

The DoD's guidelines for hunger strikes should include:

- *explicit affirmation that health professionals who evaluate and advise detainees engaged in hunger strikes should follow the standards of the World Medical Association's Declaration of Malta, including the use of*

their independent medical judgment in assessing detainee competence to make decisions;

- *maintenance of confidentiality between detainees and physicians;*
- *provision of advice to detainees that is consistent with professional ethics and standards;*
- *prohibition of force-feeding and the use of physical restraints;*
- *access to independent medical advice when detainees request it;*
- *training of health professionals deployed to detention facilities in the ethical management of hunger strikes in accordance with the Declaration of Malta;*
- *institution of informed refusal and advance directives so that detainees can express their intent regarding feeding;*
- *development of policies and protocols for alternative means of resolving detainee grievances.*

The DoD should rescind all policies, protocols, and instructions to the contrary.

Finding 5. The military system of quality assurance, credential review, and discipline of military health professionals fails to ensure that health professionals who engage in abuse of individuals in custody or do not provide competent treatment to abused detainees are held accountable for their acts.

Recommendation: The DoD quality assurance system, including the Medical Quality Assurance program and Clinical Quality Management in the Military Health System, should include measures of compliance with professional standards of detainee treatment. These measures should include adequacy and appropriateness of clinical diagnosis, treatment, and documentation; confidentiality of information; and refraining from abuse as well as reporting abuse of detainees. Measures of compliance should be revised periodically to reflect changes in ethical principles established by the health professional associations. Violations should be reported to the National Practitioner Data Bank, the Federation of State Medical Boards, and the Association of State and Provincial Psychology Boards, which should share relevant information with state licensing boards, specialty certification boards, and medical associations for appropriate action.

Finding 6. In response to the revelation of health professional participation in detainee abuse, medical associations have properly clarified ethical standards to affirm that physicians should not participate in interrogation or any practices related to interrogation, torture, or abuse. In addition, the American Medical Association has affirmed the World Medical Association's stance that physicians should not force-feed hunger strikers. However, additional clarification and elaboration of standards is necessary, as are proactive steps to ensure the United States' adherence to ethical standards regarding interrogation and conditions of detention, treatment of detainees, and proper medical management of hunger strikers, including prohibitions of force-feeding. The American Psychological Association, while reaffirming its opposition to torture, has inappropriately continued to affirm the propriety of psychologists participating in interrogation.

Recommendation: Professional medical associations and the American Psychological Association should strengthen their ethical standards regarding interrogation and detention of detainees and take proactive steps to foster compliance with those standards.

The American Medical Association, American College of Physicians, and the American Psychological Association should:

- *develop, distribute, and promote further refinements in ethical principles regarding interaction with prisoners and detainees, including roles in interrogation, conditions of confinement, abuse reporting, confidentiality of detainee medical records, and treatment of detainees including hunger strikers;*
- *reaffirm adherence to professional ethical standards in military detention settings by issuing policy and position statements, speaking out, and providing professional and public education programs;*
- *conduct fact-finding investigations regarding the involvement of physicians and psychologists in incidents of torture and other forms of cruel, inhuman, or degrading treatment of detainees in military detention settings;*
- *take disciplinary action against members who have violated standards of professional conduct;*
- *support state legislation to strengthen the authority of licensing boards to discipline health professionals who engage in torture.*

The American Psychological Association should repudiate the report of its Presidential Task Force on Psychological Ethics and National Security that condones the participation of psychologists in interrogation and adopt ethical

standards regarding participation in interrogation that follow the standards adopted by medical associations.

Finding 7. Licensure by a state agency or board is a condition of employment for military physicians and psychologists, and should be a requirement for intelligence agency physicians and psychologists as well. State agencies retain the authority and responsibility to discipline licensed health professionals who have engaged in professional misconduct, which under the laws governing professional conduct applies to abuse of detainees. Licensing and disciplinary boards have dismissed all cases brought against health professionals for involvement in detainee abuse, most on procedural grounds or by substantive decisions inconsistent with the obligations of health professionals as required by law.

Recommendation: Through legislation and other appropriate mechanisms, states should make explicit that supporting interrogation and participating in torture or cruel, inhuman, or degrading treatment are forms of sanctionable misconduct by licensed health professionals. State licensing boards, as appropriate under state law, should establish adequate procedures for fair investigation and adjudication of complaints about abuse of prisoners and detainees. Congress should support the ability of states to discipline members of U.S. military and intelligence agencies who engage in prisoner abuse.

State law should provide the following:

- *Professional misconduct includes (a) participation or complicity in torture and other forms of cruel, inhuman, or degrading treatment of a prisoner; (b) violations of professional norms in connection with interrogation, including any form of participation in, or sharing of medical information regarding, an interrogation; and (c) use of professional expertise to advise on a prisoner's conditions of confinement in a manner that impairs the well-being of the prisoner.*
- *Health professionals have a duty to report incidents of suspected torture or abuse of prisoners to the appropriate authorities and failure to do so constitutes misconduct. Individuals who provide good-faith reports of torture or abuse to state disciplinary boards will be protected from reprisals.*
- *Disciplinary boards have jurisdiction to investigate and prosecute licensees for misconduct regardless of the location, timing, or circumstances of the misconduct. Disciplinary boards must (a) investigate non-frivolous complaints of prisoner abuse, (b) prima facie charge the licensee when it finds probable cause of a violation, (c) articulate specific reasons for dismissal of a complaint*

alleging prisoner abuse and inform the complainant of the nature and scope of its investigation, and (d) formally prosecute complaints of prisoner abuse in hearings that afford the complainant opportunity to testify and call witnesses. Disciplinary boards have the authority to subpoena evidence and compel witnesses in cases involving prisoner abuse.

- *Judicial review of a disciplinary board decision to dismiss a complaint involving prisoner abuse is available to a complainant.*
- *Misconduct complaints based on prisoner abuse cannot be time-barred.*

The DoD and CIA should cooperate with state licensing and disciplinary boards in cases where detainee abuse is alleged. Congress should support the state disciplinary process in cases involving abuse of detainees by mandating cooperation by the DoD and CIA as well as providing financial resources to and sharing relevant evidence with state disciplinary and licensing boards.

Finding 8. The military's medical education programs and pre-deployment trainings lack transparency and fail to provide military health professionals with the skills and ethical grounding necessary to ensure that they protect the human rights of detainees. Curricula on medical participation in torture do not reflect the requirements of law or ethics.

Recommendation: The DoD should reform education and training of military health professionals to ensure compliance with professional ethical responsibilities toward detainees. It should require that medical schools (including the Uniformed Services University of the Health Sciences), military graduate education programs, officer training schools, and military deployment training programs certify health professionals' knowledge of professional ethical principles regarding treatment of detainees.

- *The U.S. military should provide ethics and human rights training for military physicians at its medical school, in basic officer training, and in pre-deployment training. That training should include review of the role of health professionals in preventing, documenting, and reporting human rights abuses. It should also include review of relevant codes, opinions, and policies of major medical organizations. The trainings should be as transparent as possible.*
- *Training in ethics and human rights applicable to military service should be mandatory for medical students at civilian universities who participate in*

the Health Professions Scholarship Program, as well as to all medical residents who will serve in the military.

- *Health professionals assigned to military detention centers should receive direct, not online, pre-deployment training in the human rights of prisoners and the ethical obligations of health professionals in these settings.*
- *A special section on dual loyalty, including relevant ethical tensions and means for addressing them, should be added to the specialty board exams of physicians who will serve in the military.*

Introduction

EVERYONE CONCERNED WITH THE INTEGRITY of medical professionalism and respect for human rights considers physician participation in the interrogation and torture of prisoners to be a violation of medical ethics and international conventions. Medical oaths and international declarations unambiguously condemn and prohibit such behavior. Nevertheless, in the aftermath of 9/11, these violations occurred at the detention camps in Abu Ghraib, Guantánamo, and elsewhere. How did physicians and other health professionals come to participate in these activities? Why were accepted principles and codes ignored? What can we learn from these events to prevent future occurrences? These are the central questions this report addresses. Although the significance of these questions is, we hope, self-evident, they are by no means simple to answer.

Probably the most enduring statement governing physician conduct is the Hippocratic Oath. Recited in varying versions by many American students when they enter and graduate from medical school, it contains the well-known and ever-relevant injunction to protect patients from “harm and injustice,” or in its more popular formulation, to do no harm. It also includes injunctions to protect patient confidentiality and to not take advantage of vulnerable patients. The oath declares: “Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.” That it specifically mentions slaves, the most vulnerable members of a society that considered them no more than property, makes evident just how distinctive are the ethical obligations of physicians.

The principles of medical professionalism continued to evolve after the establishment of the Hippocratic Oath, but almost always in a manner consistent with its values. To be sure, sociologists in the 1960s and 1970s equated professionalism with guild-like strategies to protect members’ self-interest by lim-

iting entrance to the ranks. But more recently, the concept of professionalism has received notably positive assessments from a variety of social scientists, policy analysts, and leaders of health care institutions and organizations. It serves as the basis for defining collective duties, standing out against countervailing pressures generated by the marketplace or by state authorities. Patients' interests must come first, even if they require financial sacrifices on the part of physicians and health care institutions. To claim, as some government officials have, that physicians in detention centers are not seeing "patients," is a brazen effort to subvert well-established principles. Physicians' professional responsibilities do not vary setting to setting and must supersede demands made by the state, even if that might mean less access to information considered vital to national security.

Put succinctly, the tenets of medical professionalism proscribe physicians from doing harm to any patients, from taking advantage of their vulnerability, and from violating their bodily integrity. These principles apply to military, intelligence, and civilian circumstances, to confined and open settings, and to persons who are combatants or non-combatants. Each of us, as patients and as persons, has a stake in their being respected and implemented. Psychologists embrace similar principles.

As unequivocal as these values are, the record long before 9/11 reveals instances of gross misconduct by physicians and psychologists in response to state demands. In fact, the misconduct was so gross as to inspire a number of international covenants that set standards to prevent recurrence.

The most notorious abuses by physicians occurred under the Nazi regime, including the heinous human experiments carried out in concentration camps. The details are well known through the testimony given before American jurists at the Nuremberg Doctor's Trial. The brutalities included purposeful exposure of subjects to high altitudes, frigid temperatures, and starvation, all of which usually led to death. Though not as well known because they were not made a focus of the post-World War II Tokyo military tribunal, Japanese physicians also carried out horrific medical experiments on Chinese prisoners.

The Nuremberg Doctor's Trial triggered both the punishment of the Nazi perpetrators (including the execution of seven of them) and the creation of the Nuremberg Code to govern medical research. The code was one of the first efforts to establish universal guidelines for physician conduct outside of clinical settings and traditional doctor-patient relationships. At the same time, it set strict limits on what the state could demand of physicians. Regardless of how determined a government was to acquire knowledge that would promote its war effort, researchers were required to obtain "the voluntary consent of the human

subject." Indeed, the subject had to be "so situated as to be able to exercise free power of choice," and able to terminate participation whenever he wished.¹ Thus, under no circumstances could investigators use prisoners of war or concentration camp occupants in their research.

The World War II experience sparked other pronouncements of principle that had direct relevance to physician conduct. In 1948, the newly created General Assembly of the United Nations issued a Universal Declaration of Human Rights.² Its articles addressed a variety of subjects relevant to assuring human rights: governments were not to abridge the "right to life, liberty and security of person" as well as freedom from "arbitrary arrest, detention or exile," and the right to "seek and enjoy...asylum from prosecution." The declaration also explicitly prohibited torture and other abuses: "No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment." The document did not specifically pinpoint physicians, but clearly the prohibition would preclude their collaboration in such activities. As the last article (number 30) declared: "Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms set forth herein."

The year after the UN General Assembly issued the Universal Declaration of Human Rights, plenipotentiaries from almost every country added provisions to the third Geneva Convention (originally drafted in 1929) to more fully address the treatment of prisoners of war.³ The need for the initiative, as one official of the International Committee of the Red Cross (ICRC) explained, was "sealed by the tragedy of the Second World War." The Geneva Conventions of 1949 were "intended to fill the gaps in international humanitarian law exposed by conflict."⁴ Accordingly, governments affirmed that prisoners were to be released and repatriated "without delay after the cessation of active hostilities." Regardless of whether individuals in custody are considered prisoners of war, Article 3 in common to all four Geneva Conventions specifically prohibited "murder of all kinds, mutilation, torture, cruel, humiliating and degrading treatment... of all persons in enemy hands," as well as "outrages upon personal dignity, in particular humiliating and degrading treatment."

A commentary issued by the ICRC further clarified these terms. Torture was "the infliction of suffering...in order to obtain from that person... confessions or information." The aim of the Geneva Conventions was to protect the "human dignity" of prisoners of war and to "prevent their being brought down to the level of animals." Accordingly, governments were prohibited from isolating prisoners from the outside world or from their families. With Nuremberg in mind,

the commentary insisted that physicians were to treat patients “only for therapeutic purposes.” “Biological experiments, willfully causing great suffering or serious injury to body or health,” including torture, inhuman treatment, or death, were to be considered war crimes.⁵

In disregard of these various declarations, physicians on a number of occasions over the ensuing decades directly participated in torture. Violations occurred in Chile and Uruguay during the military dictatorships of the 1970s and the 1980s. In Chile, blindfolded prisoners who were subjected to various forms of torture subsequently reported that persons they thought to be physicians periodically examined them. The physicians then informed the torturers whether the prisoners could survive additional abuse. In Uruguay, physicians participated in devising behavior modification programs involving aversive therapy that amounted to torture. Punitive measures would be reduced when prisoners became more cooperative with prison authorities. Medical societies in both countries eventually disciplined some of the physicians involved in such practices. In Chile, revulsion against the assistance that some physicians provided to the military dictatorship prompted other medical colleagues to take a leading role in bringing an end to the dictatorship.

Other forms of physician involvement in the abusive treatment of detainees took place in the former Soviet Union. Psychiatrists certified dissenters as mentally ill so that they could be incarcerated by the state in penal-like settings. In some cases, dissenters were subjected to electro-convulsive therapy. (There have been reports that some Chinese psychiatrists have also engaged in similar practices.) In a few instances, Soviet psychiatrists who protested such abuses were themselves imprisoned for their dissent.

Although the involvement of physicians in such practices is appalling and violates the fundamental principles of professionalism, it should be noted that a larger number of physicians often provided pro bono services to treat victims of torture. As one scholar has documented, “Some four thousand physicians in thirty countries were engaged in examining victims, running missions to other countries, and doing research or treatment.”⁶ Even so, in an era when so many physicians have demonstrated their revulsion against cruelty by volunteering their services to treat victims, some physicians have been complicit in torture.

With this mixed record in mind, the World Medical Association in 1975 issued its Declaration of Tokyo: “Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment.”⁷ The World Medical Association itself was founded immediately after World War II, with the British Medical Association spearheading the effort to bring national medical associations together under

one umbrella. The World Medical Association’s first initiatives were to promulgate both the Declaration of Geneva (1948), which served as an updated version of the Hippocratic Oath, and the International Code of Medical Ethics (1949). The documents declared that physicians must give “complete loyalty” to patients and adhere to the principle of never using “medical knowledge to violate human rights and civil liberties, even under threat.” In 1956 (and with amendments thereafter), the World Medical Association issued regulations explaining that, “Medical ethics in time of armed conflict is identical to medical ethics in time of peace.” It was determined to be unethical to “weaken the physical or mental strength of a human being without therapeutic justification” or to breach medical confidentiality.

The British-Northern Irish conflict prompted the World Medical Association to elaborate its position. In 1974, the British Medical Association informed the World Medical Association of suspected involvement of physicians, directly and indirectly, in the abusive interrogation of prisoners and asked the organization to initiate a wider discussion. The result, a year later, was the adoption of the Declaration of Tokyo. Its general principles echo other conventions: physicians should practice medicine “in the service of humanity,” and they are to maintain “the utmost respect for human life” and never use medical knowledge “contrary to the laws of humanity.” The declaration went on to identify several proscribed behaviors:

- The doctor shall not countenance, condone, or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures, whatever the offense of which the victim is suspect, accused, or guilty, and whatever the victim’s beliefs or motives, and in all situations, including armed conflict and civil strife.
- The doctor shall not provide any premises, instruments, substances, or knowledge to facilitate the practice of torture or other forms of cruel, inhuman, or degrading treatment or diminish the ability of the victim to resist such treatment.
- The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman, or degrading treatment is used or threatened.
- Where a prisoner refuses nourishment...he or she shall not be fed artificially.

The World Medical Association declaration was not binding on governments and could impose no penalties for failure to abide by it, but the pre-eminent

international medical body had now lent its authority to elevating professional medical ethics over state demands.

The UN General Assembly, in 1982, adopted a series of principles on the appropriate role of health professionals, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman, or degrading treatment. It affirmed the duty of physicians to avoid participation or complicity in torture. Principle 3 states: "It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health."

Finally, in 1984, the United Nations adopted its Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment.⁸ The result of decades of preparatory work, building on but going beyond its 1948 declaration, the International Covenant on Civil and Political Rights, and the 1975 Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the 33 articles of the Convention Against Torture focused on official, rather than individual, behavior. It addressed "pain and suffering...inflicted by or at the instigation of or with the consent or acquiescence of a public official or other persons acting in official capacity." This would patently apply to the behavior of physicians in military settings. The convention went on to define torture: "Severe pain or suffering whether physical or mental...intentionally inflicted on a person for such purposes as obtaining...information or a confession, punishing him for an act or intimidating or coercing him." The convention also declared that each state "shall ensure that all acts of torture are offences under its criminal law" and that if it does not extradite a torturer to face prosecution in another jurisdiction it shall "submit the case to its competent authorities for the purpose of prosecution." The convention also bans the use of cruel, inhuman, or degrading treatment or punishment.

The convention also urged that "education and information regarding the prohibition against torture [should be] fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials, and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention, or imprisonment." Finally, the convention declared that victims of torture should obtain redress and compensation, including full rehabilitation.

In 1988, the United States joined 63 other countries in signing the convention document, which was then ratified by the U.S. Senate in 1994. (The Senate added reservations, declarations, and understandings that the U.S.

Constitution trumped any of the convention's provisions and adopted a somewhat different definition of torture.) The ratification also prompted Congress to criminalize torture committed outside the United States and define torture as "an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering...upon another person within his custody or physical control."⁹ The statute went on to define severe mental pain and suffering as 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;
- 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.

The major U.S. medical associations that produce relevant ethical principles—the American Medical Association and the American College of Physicians, as well as the American Psychological Association and the American Psychiatric Association—followed the World Medical Association's lead, and well before 9/11 adopted strong and unequivocal standards against physician participation in torture or other forms of cruel, inhuman, or degrading treatment. This report will establish that as facts about health professionals' behavior emerged, the associations generally strengthened their standards.

Despite the existence of compelling and comprehensive human rights principles, medical professional ethics, and statutory provisions, following the tragic events of 9/11 the United States initiated a "war on terror" that involved not only the invasion of Iraq and Afghanistan, but also the indefinite detention of many hundreds of so-called "unlawful combatants." In the course of that detention, widespread use was made of "enhanced interrogation" techniques including waterboarding, wall-slammings, and extreme sleep deprivation. It also included other abusive methods not deemed enhanced, such as isolation, religious and sexual humiliation, threats, inducement of fear, forced nakedness, and hooding. All of these practices clearly violated international, professional,

and national principles against torture and cruel, inhuman, and degrading treatment in detention and interrogation.

Journalists, human rights groups, congressional committees, and others have closely investigated the record, but it remains far from complete. Regrettably, the current administration has not adequately investigated what occurred. Although there is evidence of involvement of health professionals in these practices, the full extent of the involvement remains unclear. So too, we need to know more about the military and intelligence-agency structural and operational components that were instrumental in producing the involvement of health professionals, components that may be illuminated by a report of the Senate Intelligence Committee that at the time of this report has not been publicly released, even in summary form that avoids disclosure of classified information. Finally, only limited attention has been devoted to devising reforms in standards, programs, and practices that would help ensure that health professionals do not engage in such behavior in the future.

In an effort to fill these gaps, the Institute on Medicine as a Profession (IMAP) and the Open Society Foundations convened a task force composed of legal, human rights, medical, and military experts. The Task Force on Preserving Medical Professionalism in National Security Detention Centers (Task Force) met regularly between December 2009 and January 2012. Its members authored and reviewed chapters and policy proposals for the group to consider. The report that follows represents the Task Force's analyses, findings, and recommendations.

The review the Task Force has conducted is based on the existing public record, including policies, rules, and guidelines from relevant agencies; documents the government has released under the Freedom of Information Act; documents filed in judicial proceedings; reports of human rights organizations, journalists, and scholars; and reports from the ICRC that have been leaked and now appear in the public domain. The existing public record is incomplete because many documents released by the Department of Defense and CIA are heavily redacted and interrogation logs remain classified. In addition, the Task Force did not interview health professionals who were assigned to detention facilities. Abuses recounted here could thus represent a fraction of the abuses that took place.

Where gaps in knowledge exist, we note that information is missing and discuss its importance and its potential impact on the issue assessed, as well as the value of further investigation. We have made every effort to reach conclusions that are supported by the facts known; we have tried as best we could not to reach judgments on the basis of what was likely or probable. In a few instances,

a member of the Task Force had personal knowledge of facts discussed, but consistent with an approach that relied on the public record, the report is not based on information obtained by any of its members in another capacity. Additionally, because of the professional roles they play, some members of the Task Force may have a personal stake in the report's findings and conclusions; in such instances, we disclose that fact in the discussion. The Task Force sought consensus on findings and recommendations. Members agreed to approve the final product, however, even when they did not agree with every statement and recommendation.

This report covers four main detention venues: military-run sites in Afghanistan, military-run sites in Iraq, the U.S. military detention facility at Guantanamo Bay, and CIA secret detention facilities ("black sites"). It does not cover post-9/11 detainees held in prisons and other detention facilities within the United States. Through the process of what was called extraordinary rendition, the United States also sent individuals for interrogation to third countries that were known to use torture in the interrogation of detainees. The treatment of detainees held by these third countries is not covered in the report.

A note on the terminology used in this report: While the primary focus of the report is on physicians and psychologists, the Task Force is fully alert to the involvement of other health care professionals. When a document refers to the specific category of medical personnel (e.g., physician or psychologist), this report refers to that individual using the same term. In many of the documents, however, no specific occupation is identified. In such cases, we use more general terminology, either "health professional," where the context is clear that it refers to someone holding a professional license, or "medical personnel," which includes all occupations in the health field, including physicians, psychologists, registered nurses, nurse practitioners, physician assistants, corpsmen (U.S. Navy or Marine-trained enlisted medical personnel), medics (U.S. Army-enlisted medical personnel), and technicians. In CIA documents, "medical officer" is frequently used. According to current position descriptions on the CIA's website, a medical officer is a physician,¹⁰ but the CIA's Office of Medical Services guidelines on medical support for interrogation, which are discussed extensively in this report, refer to physician assistants as medical officers as well,¹¹ so the Task Force does not assume that a CIA medical officer involved in interrogation activities is a physician unless the document so specifies.

The report opens with a review of the existing record of participation of health professionals in torture and cruel, inhuman, and degrading treatment, followed by an examination of the organizational structures and policies that led physicians and other health professionals to participate in interrogation and

torture. It next explores the compromised role of physicians in the force-feeding of hunger strikers. The report then examines the ethical and professional training that physicians, both military and civilian, receive. The report goes on to analyze the role that professional medical and psychological associations have played, and should play, in combating abuses. It devotes special attention to potential disciplinary sanctions that could be imposed by state licensing and disciplinary boards.

The role of health professionals in abuse of prisoners in U.S. custody

IN THE MONTHS AFTER THE ATTACKS OF 9/11 and the start of the U.S.-led war in Afghanistan, individuals allegedly associated with the Taliban, Al Qaeda, or other groups identified as terrorist were captured by the U.S. military and CIA in Afghanistan, Pakistan, and elsewhere or turned in by individuals seeking bounties.¹ Intelligence and military officials sought information from these detainees about plans for additional attacks on the United States as well as about the structure and operation of their terrorist networks.² White House and other U.S. officials believed that these individuals had been trained by al Qaeda in techniques to resist traditional methods of interrogation and, in the service of breaking that resistance, decided to remove existing constraints on the use of highly coercive interrogation methods that were not permitted under existing U.S. laws and regulations.³

In January 2002, the White House counsel released an opinion asserting that the Geneva Conventions did not apply to detainees in Afghanistan and elsewhere in U.S. custody. The next month, President Bush issued a directive claiming that all detainees were “unlawful combatants” who did not qualify as prisoners of war under the Geneva Conventions. In September 2002, Cofer Black, head of the CIA’s Counterterrorist Center, testified before Congress about the change in attitude regarding the pursuit of intelligence from those in custody: “After 9/11, the gloves came off.”⁴

Although the U.S. military and the CIA differed in their rules, command structures, forms of oversight, and number of detainees encountered, their use of interrogation methods were similar. The military operated large detention facilities, first in Afghanistan, and then in Guantánamo and Iraq, which all together detained thousands of individuals. By contrast, the CIA selectively interrogated individuals in military custody and operated secret detention centers around the world that it said held a total of 98 “high-value” detainees.⁵ The

military and CIA had in common the aim of inducing psychological dislocation and maximizing feelings of vulnerability and helplessness to reduce or eliminate the detainee's resistance to yielding information. To achieve these objectives, the military and CIA combined use of long-term isolation, sleep deprivation, sustained shackling in awkward positions that stressed limbs and muscles, sensory deprivation, sexual and other forms of humiliation, inducement of fear, threats to the body and lives of detainees and their families, beatings, exposure to extreme temperatures, bombardment with loud noise, and in the case of the CIA, waterboarding.⁶ Some of these methods were described by the military and the CIA as "enhanced" techniques of interrogation that were subject to legal review by the U.S. Department of Justice, but some of the methods, such as sustained shackling, forced nakedness, isolation, sensory deprivation, and threats, were not designated as enhanced and so were not subject to that review.

Under both domestic and international law (with slight variations in language), torture comprises the intentional infliction of severe mental or physical pain or suffering on a person under color of law to gain information or for other purposes.⁷ Treaties and domestic law also bar the infliction of cruel, inhuman, or degrading treatment on a person. Many of the methods of interrogation used by the United States after 9/11 have been recognized as torture by international bodies responsible for monitoring and preventing the use of torture—and by the United States in its critiques of other countries' human rights record.⁸ From a medical standpoint, too, the techniques used inflict severe mental pain or suffering.⁹

The abusive techniques used by the U.S. represented a major departure from pre-existing interrogation rules as set out in the U.S. Army's field manual on interrogation—so major that the FBI reportedly refused to participate in or support military or CIA interrogations that involved the enhanced methods.¹⁰

Through a series of opinions issued in 2002, 2005, and 2007, the Department of Justice reinterpreted the laws prohibiting torture and cruel, inhuman, or degrading treatment so as to permit the abusive interrogation practices used by the military and CIA. As a result, military and intelligence-agency physicians and psychologists, acting under directives and protocols developed by authorities, aided in the design, implementation, and monitoring of torture.¹¹ They did so in violation of U.S. criminal laws and international treaty obligations, as well as their professional ethical obligations to refrain from any form of participation in torture or using their professional skills to bring about harm to an individual.

The existing record for military detention facilities shows that health professionals' conduct under directed circumstances included acts of commission as well as acts of acquiescence or failure to act in the face of torture or cruel, inhu-

man, or degrading treatment. The record of practices by psychologists and physicians in CIA detention facilities is sparser, as most of the agency's evidentiary record remains classified. From internal documents, opinions, and reports that have been released, as well as from results of congressional hearings and investigations, International Committee of the Red Cross (ICRC) reports, and detainee accounts, however, it is known that military physicians and other health professionals working for the CIA engaged in many of the same kinds of practices as their U.S. Army counterparts, and in addition participated in the design, use, and monitoring of waterboarding.¹² CIA medical and psychological personnel also contributed significantly to the development of CIA and Justice Department policies and legal justification for the use of abusive interrogation methods, including waterboarding.¹³

The Task Force is concerned with the conduct of health professionals, by which we mean to include individuals with an academic degree in a health field and who are licensed by a state to practice their profession. Within this group, our principal focus is on physicians and psychologists, as there is almost no information in the public record on the conduct of other health professionals (except nurses, who evidently played a role in force-feeding hunger strikers). There is evidence, however, that non-professional medical personnel who interacted with detainees also played a role in torture and other forms of cruel, inhuman, or degrading treatment.¹⁴

It is not known how many doctors and psychologists breached their ethical duties through participation in the planning and practice of torture and other forms of torture or cruel, inhuman, or degrading treatment. Many military health professionals assigned to clinical rather than intelligence functions likely tried to perform honorably, consistent with ethical standards, in an environment of severe human rights violations.

In 2006, the U.S. Supreme Court determined that Common Article 3 of the Geneva Conventions, which prohibits any violence and outrages on personal dignity, including humiliating or degrading treatment, applies to detainees in U.S. custody.¹⁵ Further, Congress enacted legislation to identify certain forms of interrogation as war crimes. Also in 2006, the Bush administration reversed its policy of forbidding the ICRC to visit any of the CIA's high-value detainees, granting the ICRC access to the detainees it moved from at least some of the secret sites to Guantanamo.

In addition, in 2006, the Army issued a new field manual on interrogation that repudiated most forms of torture and cruel, inhuman, or degrading treatment authorized in the post-9/11 period.¹⁶ The Field Manual on Human Intelligence Collector Operations adopted a "golden rule" standard: if a technique would not

be considered justified for use on an American soldier in custody of an enemy, it should not be used on an enemy or suspected enemy of the United States. A directive issued in 2012 stated that use of techniques derived from the Survival, Evasion, Resistance, Escape (SERE) program for training American soldiers to resist torture—as described later in this chapter—are prohibited.¹⁷

However, in contradiction to that approach, the field manual, as well as the Department of Defense (DoD) instructions issued at the highest civilian level, continue to authorize the military's use of isolation (characterized as "separation"), sleep deprivation, and certain other forms of torture or cruel, inhuman, or degrading treatment for detainees that the United States does not deem prisoners of war under the Geneva Conventions.¹⁸ Additionally, the CIA continued to seek authorization for its own use of enhanced interrogation methods, including extended sleep deprivation of up to 96 consecutive hours through the use of forced, shackled standing; limitation of caloric intake to 1,000 calories a day; slaps to the abdomen and face and grabbing the detainee by the face; and whipsawing the detainee so violently that a towel or other collaring device must be used on the neck to prevent whiplash. Contrary to a fair reading of the requirements of Common Article 3 of the Geneva Conventions, the Justice Department opined in the summer of 2007 that the CIA's enhanced interrogation methods could be used consistently with Common Article 3 and U.S. law.¹⁹

Upon taking office in January 2009, President Obama issued an executive order reaffirming the applicability of Common Article 3 for all detainees in U.S. custody and specifically overturning the Justice Department opinions that the CIA's enhanced interrogation methods did not constitute torture or cruel, inhuman, or degrading treatment or other violations of Common Article 3. The executive order also applied the restrictions of the U.S. Army field manual to the CIA²⁰ and requested the closing of CIA detention facilities. President Obama also requested a review of practices at Guantánamo, which was conducted by Admiral Patrick Walsh in 2009. The review stated that conditions and practices at Guantánamo met the requirements of Common Article 3 and that practices including sensory deprivation, isolation, and excessive use of force and shackling had ended, although lawyers and nongovernmental organizations familiar with the treatment of detainees at Guantánamo criticized how the investigation was conducted and disputed some of the conclusions.²¹

Despite this repudiation of torture by the United States since 9/11, there has never been a comprehensive investigation of the role of health professionals in the torture and cruel, inhuman, or degrading treatment of persons in the nation's custody. The DoD has conducted a number of internal investigations of military detention practices, some of which examine issues related to the role

of health professionals and other medical personnel, and portions of which have been released to the public. In 2005, the Army Surgeon General conducted a survey of currently and previously deployed medical personnel at detention facilities in Iraq, Afghanistan, and at Guantánamo, most of which is available publicly. In 2009, the DoD's Inspector General for Intelligence conducted a review of allegations of the use of mind-altering drugs for interrogation. At the CIA, in 2004, the Inspector General conducted a review of interrogation practices, and while it briefly considered the roles of medical personnel, it did not examine them in any depth.

In addition, Congress has conducted two investigations: The Senate Armed Services Committee issued a report on the origins and conduct of U.S. interrogation practices after 9/11, with particular attention to methods derived from the SERE program and the role of Behavioral Science Consultation Teams (BSCTs), which are discussed later in this chapter. The Senate Select Committee on Intelligence has conducted an investigation resulting in a report that is reported to be more than 5,000 pages. As of this writing, the committee has not decided whether to release any portions of the report to the public.

A comprehensive investigation would require interviews with and independent medical examinations of detainees as well as reviews of interrogation logs, medical records of detainees, and any memoranda that have yet to be released on the treatment and condition of prisoners.

According to a Department of Justice memorandum issued in July 2007, the number of detainees in CIA custody numbered 98, 30 of whom had been subjected to enhanced interrogation methods.²² The number of detainees held in military custody, by contrast, likely has exceeded 100,000. As of November 2005, 10 months before the DoD repudiated most of its highly coercive interrogation methods, a total of 83,000 individuals had been held in facilities in Afghanistan, Iraq, and at Guantánamo Bay since the U.S.-led invasion of Afghanistan in late 2001. In November 2005, 14,000 individuals were in custody, most of them in Iraq. Of these, more than 5,500 had been held for more than six months and more than 3,800 of them had been held for more than a year.²³

Between 2002 and 2005, more than 100 detainees died while in U.S. custody, including 43 reported homicides.²⁴

Without a full investigation, we cannot know how many of these detained individuals were subjected to the interrogation methods described in this report. It is known that in certain periods, especially between 2001 and 2004, methods such as isolation, forced nakedness, hooding, humiliation, bombardment with loud music, stress positions, and sleep deprivation were routine, so it is likely that many thousands of people who passed through the detention

facilities in Afghanistan (between 2001 and 2004) and Iraq (in 2003 and 2004), as well as the approximately 700 detainees at Guantánamo, were subjected to these methods for at least some period of their confinement. It is also likely that detainees who were brought to Bagram Air Base prisons and the Kandahar prison in 2001 and early 2002 were severely beaten and subjected to brutal stress positions.

Without a full investigation, we also cannot determine the number of intelligence or military medical and psychological personnel who were present during these abuses or participated in them in some way. The number of CIA “black sites” was small, but they were spread around the globe and likely had medical personnel at each site. In the military, because the BSCTs were composed of only three individuals, the total number of individuals who participated over the course of the past decade is likely to be small. Deployments of clinical military personnel tended to be short, but the number of such individuals may be significant.

The onset of torture in Afghanistan

Shortly after the United States attacked Afghanistan in 2001, the U.S. military began to take people into custody, both in Afghanistan and Pakistan, and established detention facilities at Bagram Air Base and in Kandahar, Afghanistan. The Bagram facility was a converted Soviet machine shop in which detainees were held in cages built of barbed wire or corrugated metal; in Kandahar, detainees were held in tents, airport buildings, and Quonset huts.

The accounts of former Guantánamo detainees previously held in Afghanistan in the period of 2001-2002 consistently show that they were subjected to beatings. These beatings often took place daily, and guards used sticks as well as their fists to hit detainees in the head and genitals as well as on their back, legs, abdomen, and the side of the leg above the knee.²⁵ Guards slammed detainees into walls and used military dogs to intimidate and sometimes bite them. Some detainees lost teeth from beatings in the head and face. Others lost consciousness. Especially at the Bagram detention facility, people were also subjected to excruciatingly painful suspensions, sometimes upside down, from the barbed wire or ceilings. Detainees were handcuffed for weeks or months at a time, leading to painful musculoskeletal injuries. They were bombarded with loud music and lights were kept on at all times.²⁶

According to a post-Abu Ghraib review conducted by Admiral A. T. Church, at least two men died in late 2002 as a result of severe beatings at Bagram. Doctors conducting post-mortem examinations either misrepresented evidence

of trauma or performed examinations that were so inadequate as to overlook the evidence.²⁷ Detainees were also subjected to extreme cold, and to degradation and humiliation, including forced nakedness and defecation in full view of others. Though the cells were very crowded, detainees were forbidden to talk with one another. Officials also used constant bright lighting, noise, vision restrictions, deprivation of sleep, and alterations in timing of meals, designed to disrupt detainees’ sense of time.²⁸

The torture and cruel, inhuman, or degrading treatment at Bagram and Kandahar during these early years appears to have been more often ad hoc than systematic, and evidence of the role of health professionals in these practices remains fragmentary. At the time, medical services were disorganized and chaotic—theater-level guidance for organizing and providing medical services to detainees in Afghanistan was not issued until 2004.²⁹ There are indications, though, that medical personnel were used as adjuncts to interrogation and security procedures. Detainees allege that medical personnel administered humiliating and painful rectal examinations, purportedly as part of security procedures, and treated detainees for the injuries suffered in beatings and other forms of torture or cruel, inhuman, or degrading treatment.³⁰ Given the pervasiveness of detainee abuse, medical personnel were likely aware of the torture or cruel, inhuman, or degrading treatment at Bagram and Kandahar during this period. But no procedures for medical personnel to investigate or report that abuse were in place.³¹

The engagement of CIA health professionals in interrogation design, approval, and implementation

ORIGINS OF CIA TORTURE

As alleged terrorists were captured in Afghanistan and Pakistan after 9/11, the CIA opened secret detention facilities, so-called black sites, for interrogation. These prisons, operated in nondescript buildings in Europe as well as the Middle East and Asia, housed individuals identified as high-value detainees whose custody the United States had not officially acknowledged until President Bush announced their transfer to Guantánamo in 2006. Their right under international law to receive visits from the ICRC was never respected. CIA physicians were brought in to provide them with medical care.³²

The CIA contracted with psychologist James Mitchell, a former military trainer in the pre-9/11 SERE program that helped U.S. armed services personnel withstand abusive detention and torture (discussed below), to design an inter-

rogation program. The so-called enhanced interrogation techniques he recommended were designed to disorient detainees, induce hopelessness and dependence on the interrogator, and lead to a decrease in detainees' cognitive functions.³³ His approach was an outgrowth of an extensive program of research during the Cold War on brainwashing, mind control, and interrogation, including techniques the Chinese Communists had used during the Korean War.³⁴

The goal of the approach was "to create a state of learned helplessness and dependence conducive to the collection of intelligence in a predictable, reliable, and sustainable manner."³⁵ The CIA had earlier referred to the approach as designed to bring about "debility, dependency and dread." As the CIA Office of Medical Services (OMS) later summarized, the goal of the approach was to "psychologically 'dislocate' the detainee, maximize his feeling of vulnerability, and reduce or eliminate his will to resist.. efforts to obtain critical intelligence."³⁶ The Justice Department further explained the goals of this interrogation strategy in its 2007 memorandum, issued by the Office of Legal Counsel: "The program is designed to dislodge the detainee's expectations about how he will be treated in U.S. custody, to create a situation in which he feels that he is not in control, and to establish a relationship of dependence on the part of the detainee. Accordingly, the program's intended effect is psychological; it is not intended to extract information through the imposition of physical pain."³⁷

The CIA used sensory deprivation, isolation, what it called "self-inflicted pain" (induced by forcing detainees into stress positions for long periods of time and thought by the CIA to add the psychological dimension of self-blame), and other techniques.³⁸ These practices were originally discussed in the KUBARK manual (1963)³⁹ and were refined 20 years later in the Human Resource Exploitation Training Manual, an interrogation manual the United States developed for Central American military and intelligence organizations.⁴⁰

In the period after 9/11, the CIA consulted with psychologists who were familiar with these ideas and who had been associated with the military's SERE (Survival, Evasion, Resistance, Escape) program, which was designed after the Korean War to help soldiers withstand torture if captured by forces that did not abide by the Geneva Conventions. SERE trainees were subjected for limited periods to isolation and other forms of sensory deprivation, sleep deprivation, stress positions, and waterboarding, among other techniques. Mitchell and the other SERE psychologists successfully advocated for converting these methods used to defend against torture into interrogation techniques to be used against detainees as a way of disorienting them, fostering dependence on the interrogators, and creating a sense of despair.⁴¹

In Mitchell's view, these approaches were also consistent with research in the phenomenon of "learned helplessness," developed by psychologist Martin Seligman, who conducted research on dogs starting in the 1960s. The research demonstrated that physical and emotional abuse, especially in an environment of unpredictability, could induce passivity and dependence to the point where the animals would accept electric shocks even when they had a chance to resist. In the 1970s and 1980s, Seligman expanded the theory of learned helplessness to account for and treat depression in children and adults. His theories were not developed for intelligence gathering, but after 9/11, intelligence officials were intrigued by the idea that they could manipulate the environment, senses, expectations, and anxieties of detainees to get them to talk. Seligman was invited to lecture at the SERE school and even after the DoD claimed to have abolished the use of torture, the theory of learned helplessness was for a time a required element of training for psychologists who aided interrogation.⁴²

By early 2002, the CIA had decided to use SERE methods for interrogation⁴³ and sought Department of Justice approval for the use of 10 such methods in the interrogation of a man in their custody known as Abu Zubaydah, considered to be a detainee of importance with substantial information. The purpose of these methods, the Justice Department lawyers understood, was to "dislocate his expectations regarding the treatment he will receive and encourage him to disclose crucial information."⁴⁴ The methods proposed were "attention grasp" (grabbing a detainee's shirt collar with both hands and quickly pulling the detainee toward the interrogator), "walling" (pushing a detainee into a wall), "facial hold," "insult slap to the face," confinement in a box that could be as small as a coffin, standing the detainee 4-5 feet from a wall and forcing him to lean against it with his weight supported only by his fingers and without the opportunity to move or reposition his hands or feet, stress positions designed to induce muscle fatigue, sleep deprivation, cramped confinement with an insect,⁴⁵ and waterboarding. Other methods, including isolation, were not considered to be enhanced methods by the CIA, so approval was assumed.

Later, in 2005, the Department of Justice issued a memorandum legally justifying the use of 14 interrogation techniques, including most of the techniques in the 2002 memorandum. The information in the 2005 memorandum is particularly revealing since the descriptions and experiences are those of methods actually used on detainees rather than the 2002 memorandum descriptions that were derived from SERE training experiences with U.S. service personnel. The memorandum describes the use of nudity, including visibility to female officers involved in interrogation, "to cause psychological discomfort;"⁴⁶ "walling" 20-30 times consecutively, "to dispel a detainee's expectation that interrogators will

not use increasing levels of force;⁴⁷ abdominal slaps directed at the abdomen;⁴⁸ stress positions including forcing a standing detainee to lean against a wall with his head while his hands are handcuffed in front of or behind him;⁴⁹ water as cold as 41 degrees doused on the detainee through a nozzle for as long as 20 minutes (or up to 40 minutes at 50 degrees or 60 minutes at 59 degrees);⁵⁰ “flicking” water at the detainee’s face by use of the interrogator’s finger “to instill humiliation;”⁵¹ sleep deprivation for up to 180 hours (more than a week) by forcing a detainee to stand with handcuffs attached to the ceiling and legs shackled to the floor or by shackling him to a small stool;⁵² and waterboarding through the pouring of water on a cloth over a detainee’s face while inclined head down for up to 40 seconds such that “it is difficult—or in some cases not possible” to breathe (and if the detainee seeks to turn his head away, allowing the interrogator to use his hands as a dam to prevent the water from running off).⁵³

JUSTICE DEPARTMENT REVIEW

AND THE ROLE OF HEALTH PROFESSIONALS

A Justice Department legal review of the 10 enhanced methods, released in August 2002, reveals that psychologists played a role in both developing the methods and in justifying their use. The review noted that a SERE psychologist “has been involved with the interrogations since they began.”⁵⁴ The CIA told the Justice Department that it had consulted psychologists involved in the SERE program (as well as other psychologists) and “mental health experts” on potential harms from use of the proposed methods. The Justice Department Office of Legal Counsel cited these opinions to support its conclusion that the enhanced methods did not result in severe mental or physical harm to detainees:

*You have consulted with interrogation experts, including those with substantial SERE school experience, consulted with outside psychologists, completed a psychological assessment and reviewed the relevant literature on this topic. Based on this inquiry, you believe that the use of the procedures, including the waterboard, and as a course of conduct [sic] would not result in prolonged mental harm.*⁵⁵

As many SERE staff recognized at the time and as the Inspector General of the CIA later acknowledged, however, there were enormous differences between the use of SERE techniques in the controlled environment of military training and their use in coercive interrogation of “enemy combatants.” SERE was designed to build soldiers’ resistance, not to discover ways to break resistance, yet the psychologists who proposed using SERE methods in detainee interrogation did not remark on the stark differences between using such tech-

niques for a limited period on willing trainees who could end the process at any time and detainees who were being held in indefinite detention. Nor did they comment on the cumulative impact of these methods.⁵⁶

The studies the psychologists reviewed to support the use of SERE methods on detainees mentioned by the opinion only looked at the immediate and temporary adverse impact of enhanced techniques. The Justice Department nevertheless concluded that there were no long-term impacts because no Inspector General or congressional inquiries or complaints had been generated about the SERE training program. It also claimed that, in the U.S. Navy’s SERE training, no on-site psychologists had reported long-term mental health consequences from its use. The on-site psychologists did not follow up with the service members, however, and no evidence was cited of assessments of SERE veterans months or years after completing the training.

According to the Justice Department opinion, the CIA had also reviewed the literature on sleep deprivation and found little to be concerned about. It claimed individuals deprived of sleep for 72 hours could still perform “excellently” on visual-motor tasks and short-term memory tasks; that those individuals who did experience hallucinations typically had prior histories of psychosis; and that the lengthy sleep deprivation showed no correlation with psychosis, loosening of thoughts, flattening of emotions, delusions, or paranoid ideas. These conclusions could only have been based on a very selective and biased reading of medical studies, studies that in fact document very severe cognitive and physical impacts of sleep deprivation, including increased risk of psychopathology as manifested by hallucinations, depression (including suicidal ideation), and anxiety.⁵⁷ There is no indication in the Justice Department document that any other enhanced techniques identified in the opinion, much less other methods that did not qualify as enhanced, such as isolation, were reviewed; there is ample evidence that these, too, significantly impair mental and physical health.⁵⁸

Another role psychologists played was to conduct a psychological evaluation of Zubaydah for the stated purpose of determining whether his particular history, culture, or tendencies would make him especially vulnerable to harm.⁵⁹ The Justice Department’s opinion reviewed Zubaydah’s psychological profile at great length and claimed that he had no pre-existing mental health condition that would likely contribute to prolonged harm from the use of enhanced methods. It claimed that he was focused, self-confident, adaptable under duress, intelligent, and resilient. These traits were cited to claim that Zubaydah would not suffer from the use of enhanced techniques: “The healthier the individual, the less likely that the use of any one procedure or set of procedures as a course of conduct will result in prolonged mental harm.”⁶⁰ It

concluded that, in Zubaydah's case, the psychological assessment indicated that enhanced methods, including waterboarding, would not lead to severe pain or suffering.⁶¹

The role of physicians and other medical personnel in the CIA's use of SERE methods at the black sites, according to the Department of Justice opinion in the Zubaydah case, was intended to be different, but no less central, than that of psychologists. Doctors would be expected to perform medical evaluations of detainees before interrogation and before transfer to another facility, monitor detainees' medical condition during certain interrogations, and provide treatment to detainees.⁶² The Justice Department opinion suggested that physicians should be present to ensure that individuals subjected to enhanced interrogation did not suffer permanent physical injury or death. At the same time, the opinion implicitly recognized the dangers the methods posed by noting that "a medical expert with SERE experience will be present throughout this phase and...the procedures will be stopped if deemed medically necessary to prevent severe mental or physical harm to Zubaydah."⁶³

Detainee interviews by the ICRC are consistent with and add detail to the Justice Department opinion. Detainees alleged that medical personnel, based on their assessments of detainees, instructed interrogators to continue, adjust, or stop particular methods.⁶⁴ Khaled Sheik Mohammed told the ICRC that health personnel monitored his oxygen saturation during waterboarding and on several occasions intervened to stop the procedures.⁶⁵ Walid Muhammed Bin Attash said that while shackled with his hands above his head and his feet on the floor, his lower leg was measured daily with a tape measure, apparently for signs of swelling, by a person he assumed was a doctor. At some point the medical person ordered that he be allowed to sit on the floor, albeit with his hands still shackled above his head.⁶⁶ Another detainee also described that a medical person intervened after a long period of stress standing.⁶⁷ Detainees also confirmed that medical personnel provided medical treatment both for routine health problems and for injuries they received from the interrogation methods. The ICRC states that from the descriptions of care given by the detainees, these medical interventions were appropriate and satisfactory.⁶⁸ The detainees also reported that they received medical examinations prior to and after transfer to a different facility. Notably, one detainee reported that one of the medical personnel had told him that medical care would be contingent on his cooperation.⁶⁹

The role of physicians at CIA sites, then, was not to prevent pain, suffering, or harm to the detainee, but only to avoid *severe harm*. There are two noteworthy aspects of this shift, one regarding the concept of severity and another concerning duration. The concept of severity derives from the legal definition of

torture under international and U.S. law. Under those laws, torture is defined as the deliberate infliction of severe physical or mental pain or suffering. The Justice Department defined "severe pain" very narrowly to "extreme acts" that "are difficult for the individual to endure and [are] of an intensity akin to the pain accompanying serious physical injury."⁷⁰

Second, pain or suffering may be relatively brief in duration, but still severe, so as to constitute torture. But the Justice Department introduced the idea that for mental pain and suffering to constitute torture, it must have long-term consequences. It found authority for this shift in the federal anti-torture statute, which defines severe mental pain and suffering to be the "prolonged mental harm" caused by four practices, including application or threatened application of procedures "calculated to disrupt profoundly the senses or the personality." Congress' enumeration of specific forms of mental pain and suffering that constitute torture means that no proof of harm, much less long-term harm, is required, but the Justice Department interpreted the infliction of mental pain or suffering not to amount to torture unless it is shown that the pain or suffering would be prolonged.⁷¹

The Justice Department opinion on the Zubaydah interrogation provides the first evidence of what became a central strategy of the CIA and military in addressing ethical questions concerning the role of medical personnel in interrogation: conflating ethical standards with legal ones. The ethical standard for physicians is to avoid or minimize harm altogether, not just to avoid severe or even modest harm. Moreover, as explained below, all medical and psychological groups had forbidden participation in torture well before the attacks of 9/11. Under American Medical Association ethical standards, the physician shall "regard responsibility for the patient as paramount."⁷² In psychology, too, the obligation is stated simply and firmly. According to the American Psychological Association's ethical code, "Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable."⁷³ As will be discussed in greater detail in chapter 2, the substitution of a legal standard for a medical one by the military and CIA served to reassure medical personnel that because government lawyers had determined that all the practices were legal, their participation was acceptable.

THE OFFICE OF MEDICAL SERVICES AND EXPANSION OF THE ROLE OF HEALTH PROFESSIONALS

The role of CIA medical personnel in enhanced interrogation expanded in 2003.⁷⁴ Having received internal complaints that CIA personnel were using unauthorized

techniques and were violating the human rights of detainees, the CIA Inspector General conducted an investigation of the interrogation program early that year.⁷⁵ In the course of that investigation, the CIA's OMS complained that it had been neither consulted nor involved in the analysis of the risks of enhanced interrogation methods. The OMS also contended that the expertise of SERE psychologists on enhanced interrogation techniques was "exaggerated" and that their expertise on the use of waterboarding was "misrepresented."⁷⁶ The OMS told the Inspector General that there was "no *a priori* reason to believe that applying the waterboard with the frequency and intensity with which it was used by the psychologist/interrogators was either efficacious or medically safe."⁷⁷

Far from ending the use of waterboarding, however, OMS personnel came to oversee it, along with many other enhanced interrogation methods. The precise connection between its complaints in early 2003 and its much increased involvement in the CIA interrogation program remains unclear because so few agency documents have been released to the public. It is known that by September 2003, the OMS had drafted the first of a series of "medical guidelines" for enhanced interrogation. Although heavily redacted, all publicly released versions of those guidelines (through December 2004) called for extensive OMS oversight of CIA interrogations on the basis that "OMS is responsible for assessing and monitoring the health of all Agency detainees subject to 'enhanced' interrogation techniques, and for determining that the authorized administration of these techniques would not be expected to cause serious or permanent harm."⁷⁸ The draft guidelines reflected the CIA's replacement of the medical professional obligation to avoid imposing any harm that is not related to a therapeutic purpose with an obligation only to prevent "severe" harm. It also adopted the Justice Department's constricted definition of severe mental pain and suffering.

The OMS described its responsibilities as including medical intake evaluation, ongoing medical treatment, diet monitoring, and regular monitoring of a detainee's condition during enhanced interrogation for indications of significant physical or mental harm.⁷⁹ For waterboarding, the OMS guidelines required a medical assessment before more than 15 applications of the method within a single 24-hour period. They also provided that a physician should be present during waterboarding and that emergency resuscitation equipment and medical supplies for performing a tracheotomy (needed in case the person could no longer breathe) should be available for detainees subjected to waterboarding.⁸⁰ Physicians were permitted to intervene to stop further use of the waterboard in the case where a detainee essentially "gave up" from physical fatigue or psychological resignation, resulting in water filling the airways and

loss of consciousness. The OMS advised that an unresponsive subject must be righted immediately and a thrust just below the breastbone administered by the interrogator. The guidelines further stated: "If this fails to restore normal breathing, aggressive medical intervention is required. Any subject who has reached this degree of compromise is not considered an appropriate candidate for the waterboard, and the physician on the scene cannot concur in the further use of the waterboard without C/OMS consultation and approval."⁸¹ The Justice Department deemed the presence of medical and psychological personnel during waterboarding and certain other enhanced methods to be "critically important" to its finding that the methods were legal.⁸²

The mechanism of monitoring and oversight by medical personnel is further illustrated by their role in sleep deprivation, as described by both the Justice Department and the OMS. A 2005 Justice Department opinion describes the responsibilities of medical personnel during sleep deprivation as including that they should be alert to the presence of edema (the abnormal accumulation of fluid beneath the skin that results in swelling) and other physical or psychological conditions.⁸³ In such cases, another form of sleep deprivation would be used. The OMS recognized that using restraints to force a detainee to stand as a method of sleep deprivation could cause clinically significant edema. It required medical personnel to conduct frequent physical examinations of a detainee kept awake by forced standing.⁸⁴ It instructed them to stop the forced standing if edema appeared, although shackling could continue in another form. As the Justice Department later explained, if the "professional judgment" of medical personnel determined that "clinically significant edema or muscle stress" was in place, then "interrogators may use an alternative method of sleep deprivation." In such cases, the detainee would be "shackled to a small stool, effective for supporting his weight, but of insufficient width for him to keep his balance during rest."⁸⁵ The Justice Department also noted that medical personnel were also instructed to intervene if the detainee began to exhibit significant impairment of mental functioning or suffered hallucinations.

As the primary aim of the enhanced interrogation methods was to break the prisoner psychologically, it is not surprising that the OMS guidelines make no reference to assessing the possibility of severe psychological harm to the detainee. None of the versions describe any OMS procedures or responsibility for assessing prisoners medically or psychologically for signs of torture or cruel, inhuman, or degrading treatment.

The OMS guidelines, along with the opinion released in 2005 by the Justice Department's Office of Legal Counsel, reveal that by the end of 2003, the OMS had assumed a major role not just in clinical oversight but also as a policy advis-

er to the CIA and the Justice Department on the medical consequences of the use of enhanced techniques. The OMS reviewed each of the methods used, identified potential consequences and risks, and gave opinions on limitations that should be imposed on their use. It recognized that the risks of waterboarding, for example, included drowning, hypothermia, aspiration pneumonia, and laryngospasm (an uncontrolled or involuntary muscular contraction of the vocal cords). Dousing, with long exposure to cold water or air, could result in hypothermia and possibly death. Confinement in a box, they said, could lead to deep vein thrombosis.⁸⁶ Nevertheless, OMS physicians advised Justice Department lawyers that sleep deprivation did not unduly disrupt the senses or personality⁸⁷ and that there exists no “medical reason” to believe that waterboarding brings about physical pain,⁸⁸ though in physiological terms, it amounts to drowning.⁸⁹ According to the Justice Department, OMS doctors and psychologists also advised that the effects of combined use of enhanced interrogation methods would not be different than techniques used individually, and thus would not cause severe pain.⁹⁰

In setting limitations that should be imposed on the use of the enhanced methods, the OMS considered how long detainees could be exposed to cold, sleep deprivation, loud noise, lack of nutrition, or stress positions before, in the OMS’s judgment, severely adverse effects such as hypothermia, malnutrition, or permanent hearing loss set in. Exposure was permitted until these very high thresholds. The OMS authorized stress positions for up to 48 hours, provided the detainee’s hands were no higher than the head, the detainee’s weight was borne by the lower extremities, and pre-existing injuries were not aggravated. The OMS permitted exposure to temperatures lower than 60 degrees F for no longer than three hours.

Not only is determining degrees of pain and suffering in various forms of interrogation an activity inconsistent with the ethical duty not to participate in harm, but the manner in which the OMS performed this task did not respect medical evidence and medical literature. The OMS reviews of the methods met no criteria for scientific or medical assessments. Despite a plethora of studies that could have been consulted, the reviews were no more grounded in published studies of the impact of the enhanced methods than the psychologists’ claims in 2002 had been.⁹¹ Instead of reviewing widely available journal articles on interventions such as sleep deprivation and isolation and accounts by individuals who had been subjected to the methods of torture described,⁹² OMS cited sources like wilderness and survival guides for hypothermia, the CIA Counterterrorism Center’s own guidelines, and OSHA guidelines for decibel levels.

While definitive statements are not possible because of the very limited

record the Task Force had available, it appears that the OMS’s purpose was not to assess harm, pain, and suffering, much less to prevent them, but rather to ensure that the limitations it imposed would prevent death or permanent loss of a function like hearing. Such a purpose renders comprehensible the OMS discussion of limits on exposure to cold water or air to a level that would not likely lead to death from hypothermia, identification of decibel levels for noise exposure ostensibly just below levels that would lead to permanent hearing loss, and means of preventing possible asphyxiation from waterboarding. This purpose also explains the absence of medical limitations by the OMS on walling or cramped confinement except so as not to exacerbate pre-existing injury. These methods are extraordinarily painful and can lead to severe mental suffering, but they are unlikely to lead to death.

The Justice Department’s 2005 opinion relied heavily on the OMS’s medical opinions to claim that the enhanced techniques used by the CIA, including waterboarding, did not constitute torture or cruel, inhuman, or degrading treatment. It also cited the OMS medical opinions as a potential good faith defense by an interrogator if subjected to prosecution.⁹³ By 2007, the Justice Department took reliance on OMS-style medical clearance a further step by identifying it as one of three key determinations the CIA must make in each case it wished to employ enhanced interrogation methods. The first two determinations it required of the CIA were finding that the detainee was either a member of al Qaeda or possessed critical intelligence of high value to the United States and that enhanced methods were needed either because the detainee was withholding or manipulating intelligence or there was insufficient time to use traditional methods. The third determination was that “in the professional judgment of qualified medical personnel, there are no significant medical or psychological contraindications for their use with that detainee.”⁹⁴

The Task Force finds that the actions required by medical personnel in the CIA—using their medical skills to determine detainees’ fitness for enduring torture, approve and adjust techniques used to perform torture, and monitor the medical condition of the detainee as torture was taking place—made them participants in torture. And torture it indeed was, as found by the ICRC in its extensive interviews with detainees who had been held in CIA black sites. It found that detainees endured “systematic physical and/or psychological cruel, inhuman, or degrading treatment” and the regimen was “clearly designed to undermine human dignity and to create a sense of futility by inducing, in many cases, severe physical and mental suffering, with the aim of obtaining compliance and extracting information, resulting in exhaustion, depersonalization and dehumanization.”⁹⁵

*Engagement of military health professionals
in interrogation and other forms of torture or cruel,
inhuman, or degrading treatment*

With the transfer of hundreds of detainees to the Guantánamo Bay detention facility starting in January 2002, Secretary of Defense Donald Rumsfeld made intelligence gathering a priority. In the beginning, interrogation was disorganized and haphazard, with competing agendas by the CIA, which sought information about possible future attacks, and the FBI, which wanted to build cases for criminal prosecution.⁹⁶ By mid-February, however, the DoD set up a new military entity, Joint Task Force 170, headed by Army Major General Michael Dunlavey, to coordinate interrogation activities at Guantánamo. General Dunlavey transformed Guantánamo from a prison camp to an interrogation center, even as commanders there began to doubt the intelligence value of the detainees.⁹⁷

During the spring of 2002, the DoD, as the CIA had done before, looked to SERE as a model for interrogation. The DoD first applied these methods at Guantánamo and, after launching the war in Iraq in March 2003, it applied them in detention facilities there as well.

Early on, General Dunlavey sought to enlist the help of psychiatrists and psychologists to gain information from detainees. By mid-2002, the role of these health professionals was formalized through what the military called Behavioral Science Consultation Teams, abbreviated BSCTs and pronounced “biscuits.” These units were part of military intelligence, but at times engaged with the CIA as well. Behavioral science consultants were part of the teams that interrogated high-value detainees, formerly in CIA custody at the black sites, when they were brought to Guantánamo in 2010.⁹⁸

BEHAVIORAL SCIENCE CONSULTANTS

In December 2001, high-level officials in the DoD began requesting information from the Joint Personnel Recovery Agency, which operates the SERE program, about detainee “exploitation.” By the following spring, the agency briefed DoD officials on how detainees resist exploitation, and the agency’s senior psychologist, Dr. Bruce Jessen, proposed interrogation methods based on SERE, including sensory deprivation, stress positions, and sleep deprivation.⁹⁹ As discussions between the agency and other components of the DoD continued, the psychologist continued to advocate the use of these SERE methods in interrogation. In the fall of 2002, top lawyers from the DoD and White House visited Guantánamo and also promoted the use of these methods of interrogation, the legal authority for which had been approved that August by the Justice Department.¹⁰⁰

Around the same time, military intelligence officials tasked the Guantánamo BSCT, which had been established in June 2002 by the Joint Task Force 170, to support intelligence gathering among detainees there, and to propose specific interrogation methods. The first BSCT consisted of a psychiatrist, a clinical psychologist, and a psychological technician, but by the end of 2002 had been standardized to include a psychiatrist, a clinical psychologist, and a mental health specialist.¹⁰¹ To facilitate their assignment, the BSCT members, who had no experience either with SERE or with interrogation, were sent by the DoD to Fort Bragg, North Carolina, where SERE techniques were used in training. When the BSCT members returned to Guantánamo, they were instructed to propose interrogation methods based on SERE. The psychiatrist member of the BSCT later told the Senate Armed Services Committee that he had expressed discomfort with the use of SERE techniques on detainees but felt significant pressure from command to make recommendations for methods that were highly coercive.¹⁰²

The team recommended a three-tier system of progressively harsher interrogation techniques, some of which the BSCT psychiatrist later acknowledged the team “simply made up”¹⁰³ because of pressure they felt they were under to design coercive methods. Category one methods were “mildly aversive,” such as threatening the detainee that he would never leave Guantánamo if he did not talk. If these did not induce cooperation, category two methods were recommended. These included isolation for 30 days (renewable), stress positions, deprivation of food for 12 hours, back-to-back 20-hour interrogations once a week, hooding, deprivation of religious and comfort items, handcuffing, and forced grooming. The third category the BSCT recommended would be reserved for detainees who were suspected of having significant information pertinent to national security and who evidenced what the team called “advanced resistance.” The techniques at this level included daily 20-hour interrogations, strict isolation without the right of visitation by medical professionals or the ICRC, food restrictions for 24 hours once a week, scenarios designed to convince the detainee he might experience a painful or fatal outcome, non-injurious physical consequences, removal of clothing, and exposure to cold air or water until such time as the detainee began to shiver.¹⁰⁴

The BSCT also proposed additional detention conditions they believed would further assist intelligence-gathering operations. These included using fans and generators to create white noise as a form of psychological pressure; restricting “resistant” detainees to no more than four hours of sleep a day; depriving them of “comfort items” such as sheets, blankets, mattresses, and washcloths; and controlling their access to the Koran. “All aspects of the [detention] environment,”

they argued, “should enhance capture shock, dislocate expectations, foster dependence, and support exploitation to the fullest extent possible.”¹⁰⁵

The proposal went through reviews up the chain of command. Some aspects met serious opposition among senior officers and lawyers of the U.S. Army, Air Force, Marines, and Navy,¹⁰⁶ but the three-level system and many of the techniques the BSCT proposed were approved for general use by Secretary Rumsfeld in December 2002. Those not approved for general use could still be authorized on a case-by-case basis.¹⁰⁷ The BSCT’s SERE approach was incorporated in U.S. interrogation strategy that same month in the SERE Standard Operating Procedure for Guantánamo:

*The interrogation tactics used at U.S. military SERE schools are appropriate for use in real-world interrogations. These tactics and techniques are used at SERE school to ‘break’ SERE detainees. The same tactics and techniques can be used to break real detainees during interrogation.*¹⁰⁸

The standard operating procedure described “degradation tactics,” “physical debilitation tactics,” “isolation and monopolization of perception tactics,” and “demonstrated omnipotence tactics.” Many of these tactics mimic the CIA’s enhanced interrogation methods. Degradation tactics included the “shoulder slap” (hitting the person hard on the back and shoulder with an open hand), the “insult slap” (a slap in the cheek used to “shock and intimidate the detainee”), the “stomach slap” (hitting the abdomen with the back of the hand), and stripping the detainee of all his clothing. Stripping was also supposed to be used to demonstrate “omnipotence.” Physical debilitation tactics included stress positions such as forcing all the detainee’s weight on his fingers while leaning face-forward on a wall; placing weights on outstretched arms while he was forced to kneel on his knees; forcing the detainee’s head and torso back while he is kneeling on his knees (called “worship the gods”); sitting with arms extended horizontally; and standing while extending arms to the side with light weights on them. Isolation and monopolization of perception tactics focused on hooding. Demonstrated omnipotence tactics included “manhandling,” which was physically pushing or pulling a detainee while he was handcuffed, and “walling,” which was throwing a detainee against a specially constructed wall.¹⁰⁹

The BSCT soon became instrumental in implementing the approved methods. According to the standard operating procedure, the BSCT role was to assess the detainee’s weaknesses, advise interrogators of methods that would help exploit those weaknesses, help develop the interrogation plan, monitor the

interrogation for the detainee’s responses, and provide feedback during the interrogation process.

The full range of methods the BSCT developed was first employed at Guantánamo in the interrogation of Mohammed al-Qahtani, who was allegedly part of the 9/11 hijacking group but had been denied entry to the United States. In early October 2002, even before all the SERE methods had been approved, interrogators had already used sleep deprivation, “body placement discomfort,” isolation, frightening dog displays, loud music, and bright lights on al-Qahtani, none of which yielded intelligence information.¹¹⁰ The following month a new and even more abusive interrogation approach was approved for al-Qahtani by the head of intelligence at Guantánamo, Major General Geoffrey Miller. However, a number of lawyers, FBI agents, members of the Naval Criminal Investigative Service, and military officers objected that the approach would be ineffective and potentially subject interrogators to criminal prosecution.

As a result of the objections, the al-Qahtani plan was modified and reviewed by the DoD.¹¹¹ The final plan, approved in November 2002, included five phases of interrogation.¹¹² In the first phase, the goal was to induce and exploit the “Stockholm Syndrome,” making the detainee completely dependent on the interrogator. In the second phase, al-Qahtani’s head and beard were to be shaved and gauze placed over his mouth. The third phase involved the use of an interpreter who would pretend he was a detainee in order to elicit information from al-Qahtani. The fourth phase proposed use of the BSCT’s “level III” methods after approval by the Secretary of Defense. Al-Qahtani was subjected to all of these third-level methods, including daily 20-hour interrogations, strict isolation without the right of visitation by medical professionals or the ICRC, food restriction for 24 hours once a week, scenarios designed to convince him he might experience a painful or fatal outcome, non-injurious physical consequences, removal of clothing, and exposure to cold air or water until such time as he began to shiver. The goal was persuading al-Qahtani that it was futile to resist. The final phase of the plan was to make a determination as to whether or not to send him to a third country.

Despite continual objections from the FBI, the new round of interrogation began in late November, with the head of the BSCT present. It involved elements that had not been approved in the revised plan, including use of dogs and stress positions.¹¹³ It began with a threat to al-Qahtani that if he did not cooperate he would be sent to a third country to be tortured or killed.¹¹⁴ Over the course of 54 days, interrogators engaged in near-constant, day and night interrogation of al-Qahtani for periods exceeding a week at a time, depriving him of sleep through the use of loud noise, yelling, and demands that he stand.

Interrogators subjected him to many forms of sexual and religious humiliation, doused him with cold water (including when he was naked), employed stress positions, used a dog to frighten him, and threatened his family.¹¹⁵

According to evidence in a military proceeding, a BSCT member was present throughout the interrogation and medical personnel monitored him for dehydration and other conditions.¹¹⁶ A BSCT psychiatrist who witnessed portions of the interrogation noted that, “the [dog] was never allowed to bite the detainee but would be ordered to bark loudly close to the detainee, to sort of sniff or muzzle the detainee, to put paws up on the detainee.” The use of the dog was discontinued, he reported, “not because anybody objected,” but because the shock value had worn off, “and it just wasn’t felt to be effective anymore.”¹¹⁷ There is no evidence that any of the BSCT members formally or informally reported abuse during the course of this interrogation. At the end of the interrogation, Major General Miller, who was commander of the Guantánamo Joint Task Force and responsible for all intelligence operations there, came to the interrogation room to present awards to the individuals engaged in the interrogation.¹¹⁸

Ongoing dissension within the DoD regarding the use of SERE and other methods to break detainees, and internal controversy surrounding the al-Qahtani interrogation, led Secretary Rumsfeld to rescind some of the previously approved interrogation techniques derived from the SERE training methods and appoint a working group to review them again. In the wake of their review, Secretary Rumsfeld in April 2003 approved certain techniques, including dietary manipulation, temperature extremes, sleep “adjustment” (claimed not to be sleep deprivation), and isolation, some of which required a determination of “military necessity.”¹¹⁹ The Task Force notes, however, that the treaties and laws prohibiting torture allow for no exceptions whatsoever.

As BSCTs became established at U.S. detention facilities, their role came to include training interrogators. The Enhanced Analysis and Interrogation Training, or EAIT, course included advising would-be interrogators on how to make use of and interact with BSCTs in their work. A 2004 review by the Army Surgeon General of medical roles in detention explained:

The EAIT course emphasizes the need for students to interact with medical personnel, in particular the BSCT staff; in theaters of operation this interaction is intended to occur 2-3 times per week at a minimum. Students are trained about the roles of the BSCT staff, which include: checking the medical history of detainees with a focus on depression, delusional behaviors, manifestations of stress, and “what are their buttons.” Students are also trained that BSCT staff will greatly 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.*¹²⁰

The interrogators were judged on how much they made use of BSCTs, as indicated by the Surgeon General’s report: “During the EAIT course, trainee competency is evaluated during their planning phase for interrogation and analysis, and failure to interact with the BSCT staff is a ‘NO-GO’ in this process.”¹²¹

At the same time, subjection to SERE methods became part of the daily routine detainees endured. The March 2003 Camp Delta [Guantánamo] Standard Operating Procedures manual reflects the use of coercive and isolating conditions of detainee confinement to enhance the effectiveness of interrogation. The manual states that “the purpose of the behavior management plan is to enhance and exploit the disorientation and disorganization felt by a newly arrived detainee in the interrogation process.” To achieve this, the behavior management plan “concentrates on isolating the detainee and fostering dependence of the detainee on his interrogator.”¹²² During the first two weeks, the detainee was to be denied access to chaplains, the ICRC, books, the Koran, and prayer caps. After two weeks, the detainee remained in isolation, and the interrogator determined what contact with others the detainee would be allowed and also provided prayer beads and a prayer cap.

The line between clinical and intelligence functions remained fluid for the first year of Guantánamo’s operations, but with the establishment of the BSCTs, health professionals began to be assigned to either interrogation activities (including conditions of confinement to support interrogation) or to clinical activities. This process of role separation may have been influenced by criticisms from health professional and human rights groups after a front-page story in the *New York Times* in November 2004 revealed the existence of the BSCTs. The story discussed the content of an ICRC report, written during the summer of 2004, about conditions at Guantánamo, including the existence and role of the BSCTs.¹²³ An article about the BSCTs in the *New England Journal of Medicine* early the following year may have been influential as well.¹²⁴

Under the organizational structure that separated health professionals into either interrogation activities or clinical activities, clinicians reported to the base commander and the medical chain of command, whereas BSCT members reported to intelligence units, outside the medical chain. In June 2005, the Assistant Secretary of Defense for Health Affairs issued a memorandum formalizing this separation: health care personnel acting as behavioral science consultants were not to provide non-emergency treatment to detainees, and health

care personnel assigned to treating detainees were not to engage in non-treatment-related activities. The memo also limited the ethical obligation “to protect [detainees’] physical and mental health” only to “health care personnel charged with the medical care of detainees”; others only had the obligation to adhere to the legal requirement of upholding humane treatment.¹²⁵ As will be discussed in chapter 2, the Task Force concludes that this limitation is inconsistent with the ethical duties of health professionals.

The BSCT role was further formalized in a DoD directive on intelligence gathering in November 2005.¹²⁶ It was then spelled out in greater detail the following June in an instruction—policy issued by civilian authority to govern practices by the military services—issued by the Assistant Secretary of Defense for Health Affairs, that addressed medical roles in detainee operations.¹²⁷ This instruction remains DoD policy as of August 2013, though it is reportedly up for revision. These directives made clear that psychologists and forensic psychiatrists had evolved from ad hoc instruments of interrogation to institutional fixtures in the military interrogation process. According to these directives, BSCTs exercised the following functions:

- Making psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees, including interrogation subjects
- Based on such assessments, advising authorized personnel performing lawful interrogations and other lawful detainee operations, including intelligence activities and law enforcement
- Providing advice concerning interrogations of detainees when the interrogations are fully in accordance with applicable law and properly issued interrogation instructions
- Observing, but not conducting or directing, interrogations
- Training interrogators in listening and communications techniques and skills and on results of studies and assessments concerning safe and effective interrogation methods and potential effects of cultural and ethnic characteristics of subjects of interrogation
- Advising command authorities on detention facility environment, organization, and functions; ways to improve detainee operations; and compliance with applicable standards concerning detainee operations
- Advising command authorities responsible for determining detainees’

release or continued detention of assessments concerning the likelihood that a detainee will, if released, engage in terrorist, illegal, combatant, or similar activities against the interests of the United States¹²⁸

To “ensure that detainees do not obtain the mistaken impression that health care personnel engaged in clinical care of detainees are also assisting in interrogations,” the DoD directive stipulated, “[behavioral science consultants] shall not allow themselves to be identified to detainees as health care providers.”¹²⁹

The June 2006 instruction expressed a preference for psychologists over psychiatrists as members of the BSCTs, noting that, “As a matter of professional personnel management, physicians are not ordinarily assigned duties as [behavioral science consultants], but may be so assigned, with the approval of [the assistant secretary of defense for health affairs] in circumstances when qualified psychologists are unable or unavailable to meet critical mission needs.”¹³⁰ Guidance issued from the U.S. Army subsequent to the issuance of the instruction nevertheless continued to anticipate the participation of psychiatrists. The DoD has informed the Task Force that no psychiatrists are currently serving on BSCTs.

Because the only Guantánamo interrogation log publicly available is that of Mohammed al-Qahtani, the Task Force only had access to fragmentary information on the role BSCTs played in the interrogation of other individual detainees. The few accounts available, however, show the direct role of behavioral science consultants in torture and cruel, inhuman, or degrading treatment.

In one case, an interrogator filed an abuse report against another interrogator who, under the guise of establishing physical control over the detainee, and with direct involvement of a behavioral science consultant, brought two military police officers (MPs) into the interrogation room. The officers pressed their knees into the detainee’s back while holding his arms behind his back and slammed him to the floor 25 to 30 times. The MPs and the accused interrogator denied any wrongdoing, claiming that the detainee was only told to stand up and sit down. According to the behavioral science consultant’s account, the MPs were giving the detainee physical support. A subsequent medical examination showed that the detainee’s forearms and biceps were bruised, a kneecap swollen, and his right knee abraded. The behavioral science consultant argued that the techniques used were effective for a noncompliant detainee because the interrogator needed to establish dominance and were acceptable because the detainee’s head never hit the floor and he was not seriously harmed. After reviewing the evidence, the investigator concluded that the interrogator did indeed direct the MPs to use force.¹³¹

In the case of an adolescent detainee named Mohamad Jawad, the evidence showed that while at Bagram Air Base, Jawad was brutalized, in one instance covered with a hood, shackled, and shoved down a staircase. At Guantánamo, he was subjected to the “frequent flyer” program, designed to keep detainees from sleeping, in which he was moved more than 100 times in a two-week period, a practice a military judge later found to constitute “abusive conduct and cruel and inhuman treatment.”¹³² In late 2003, Jawad tried to kill himself by repeatedly banging his head against the wall. According to his lawyer, who was able to read interrogation files, one interrogator was sufficiently concerned about Jawad’s mental state to ask a behavioral science consultant for advice. According to the lawyer’s affidavit, in response to the interrogator’s request, the consultant conducted a psychological assessment, but not for the purpose of treatment. It was instead “conducted to assist the interrogators in extracting information from Mr. Jawad, even exploiting his mental vulnerabilities to do so.”¹³³

In addition, the Senate Armed Services Committee noted the case of Mohamadou Walid Slahi, who reported hearing voices after having been subjected to abusive interrogation, including techniques applied to al-Qahtani such as sleep deprivation, shackling, severe humiliation, sensory deprivation and overstimulation, temperature extremes, and threats to him and his mother. The BSCT psychologist brought in to advise the interrogator responded that “sensory deprivation can cause hallucinations, usually visual rather than auditory, but you never know.... In the dark you create things out of what little you have....”¹³⁴ There is no evidence that the psychologist intervened in any way to stop the interrogation or to refer the detainee for medical or psychiatric care.

These accounts, though far too small a sample to be considered representative of the thousands of interrogations at Guantánamo, are nevertheless consistent with evidence of the significant pressure on behavioral science consultants to devise and accede to interrogation methods that were highly coercive. A psychiatrist assigned to a BSCT told the Senate Armed Services Committee staff that “there was increasing pressure to get ‘tougher’ with detainee interrogations but nobody was quite willing to define what ‘tougher’ meant.”¹³⁵ He noted that “persons here at this [intelligence] operation are still interested in pursuing the potential use of more aversive interrogation techniques.”¹³⁶ He told the staff that he personally felt uncomfortable about the techniques he and his team recommended because there was no evidence that the methods worked and he had concerns that they could be harmful. Still, he went ahead with the recommendations.

According to a former senior BSCT psychologist, another young behavioral science consultant, a psychologist, became angry, exhausted, and depressed by his

role in witnessing interrogations that involved the use of dogs, sexual humiliation, forced nakedness, and stress positions. He was reported by the senior psychologist as having received “increasing pressure to teach interrogators procedures and tactics that were a challenge to his ethics as a psychologist and moral fiber as a human being” and as “devastated to have been a part of this.”¹³⁷

Despite the energy that went into the creation of the BSCTs, and their close relationship to the use of SERE methods, BSCTs remained unique to Guantánamo until after the Abu Ghraib scandal broke in the spring of 2004. In Afghanistan and Iraq, however, some psychologists had been assigned to interrogation as their core function,¹³⁸ and a psychiatrist was sent for a month-long assignment as a BSCT in Iraq in January 2004.¹³⁹

In 2006, the DoD officially repudiated most forms of torture, including reliance on methods derived from SERE.¹⁴⁰ Since then, however, the BSCTs have become ever more embedded in the structure of military interrogation. The most recent U.S. Army guidance on BSCTs was issued in January 2009 by the Army Medical Command and revised in 2012. Both versions require that behavioral science consultants be licensed psychologists and that forensic psychiatrists either be board certified or otherwise trained by the military. Enlisted non-licensed behavioral science technicians with 10 years of experience in the mental health field may also be assigned to a BSCT under the supervision of a behavioral science consultant. The guidance states that behavioral science consultants’ scope of activities are to be defined by the supervising behavioral science consultant, which places decisions concerning the scope of the technicians’ activities in the hands of individual behavioral science consultant psychologists or psychiatrists rather than establishing those decisions through policy. The reason for this approach is not explained. Although behavioral science consultants must be qualified and licensed in their fields, and maintain privileges at their parent medical facility, the guidance describes BSCT members as combatants and forbids them from engaging in clinical practice while operating in their intelligence capacity.¹⁴¹

Although the 2009 and 2012 guidance devote considerable space to describing purportedly protective roles, such as to prevent “behavioral drift” by interrogators, the core BSCT function remains to identify and exploit detainee vulnerabilities toward obtaining intelligence. One means of achieving this goal is to ensure that the detention environment “maximizes the effectiveness of eliciting accurate, reliable, and relevant information during the interrogation and debriefing processes,”¹⁴² while “maintaining the safety of all personnel, to include detainees.”¹⁴³ The BSCT mandate is as broad: “ensuring that everything that a detainee sees, hears, and experiences is a part of the overall interrogation plan.”¹⁴⁴ The guidance deems

the physical environment to include holding cells, hallways, toilet and bathing facilities, vehicles, and interrogation rooms. BSCTs also consult with all personnel, including command, on aspects of the interrogation environment that will assist in detention and interrogation operations, and perform psychological assessments of personnel for suitability to interaction with detainees.

Another BSCT function, as outlined in the 2009 guidance, is “to provide psychological expertise to assess the individual detainee and his environment and provide recommendations to improve the effectiveness of intelligence interrogations, detainee debriefings, and detention facility operations.”¹⁴⁵ This includes “psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees, including interrogation subjects, and, based on such assessments, advise authorized personnel performing lawful interrogations and other lawful detainee operations, including intelligence activities and law enforcement.” The consultant is supposed to assess the “psychological strengths and vulnerabilities of detainees, and to assist in integrating these factors into a successful interrogation/ debriefing process”¹⁴⁶ BSCTs are also expected to train interrogators and others in psychological aspects of exploitation, how to recognize a detainee’s use of resistance techniques, and similar matters.

The most recent revisions to the higher-level DoD directive on intelligence debriefing, interrogation, and tactical questioning, issued in October 2012, reaffirmed the institutional role of the BSCT as an authorized component of intelligence and interrogation operations, with a restriction only on exploiting the use of detainee phobias during interrogation.¹⁴⁷ The latest documentation thus clearly shows that BSCTs have become institutionalized in military intelligence practice, staffed by licensed psychologists and with the availability of forensic psychiatrists, and part of the apparatus of interrogation.

CLINICAL HEALTH PROFESSIONALS

The role of clinical medical personnel in interrogation has typically been restricted to medical clearance for interrogation and attending to treatment for sickness and injuries.¹⁴⁸ In some locations, their actions provided direct support for interrogation.

Afghanistan and Iraq

In the first years of the war in Afghanistan, medical services for detainees remained chaotic. Prior to the 2001 invasion, no plans had been made for the medical care of prisoners, and until 2004 no theater-level policies covered detainee medical care in Afghanistan and Iraq.¹⁴⁹ Although the level of care

provided to detainees was supposed to be “similar” to that provided to American soldiers, an internal investigation described governing directives as “vague” and made no references to the requirement of the Geneva Conventions to provide medical care to wounded and sick prisoners under the same standard of care applicable to soldiers.¹⁵⁰ Confusion about the medical standard of care due detainees was so pervasive that not a single person responding to a survey conducted in 2004 by the Army Surgeon General was familiar with documents establishing such a standard.¹⁵¹ Further, while an investigation found a commitment to humane care among health professionals working in Afghanistan detention facilities, “the general circumstance they described...make it clear they were not equipped to fully comply with all doctrinal requirements for detainee medical care.”¹⁵² At least through late 2004, regular medical checks were not performed and documentation of care when it did occur was haphazard.

In Iraq, theater-level policies on medical care for detainees were absent for two years after the war started in 2003. Directors of combat-support hospital units stationed in Iraq, when interviewed in 2004, said that they were instructed to provide medical care to detainees based on Iraqi standards.¹⁵³ Medical personnel were not trained in providing medical care for detainees. Only in 2005 did the U.S. Army seek to conform to the international standard, which is that detainees are entitled to the same standard of medical care applicable to soldiers.¹⁵⁴

Soldiers working in detention facilities in Iraq and Afghanistan repeatedly reported acute shortages of basic medical supplies, drugs, and equipment, and both internal investigations and available records confirm a severely substandard level of care for detainees and¹⁵⁵ haphazard medical recordkeeping.¹⁵⁶

Shortly after the 2003 U.S. invasion, interrogation methods used at Guantánamo were introduced in Iraq,¹⁵⁷ set out in a memorandum by Lieutenant General Richard Sanchez.¹⁵⁸ The authorized methods (some of which required specific command approval) included exposure to extremes of temperature and noise, dietary manipulation, use of military dogs, isolation, sleep deprivation, and stress positions. Despite provisions for “safeguards,” including training and command and medical review of plans, there exists overwhelming evidence that from the time of invasion at least through the public revelations of detainee mistreatment in April 2004, torture at Abu Ghraib and other locations in Iraq was severe and pervasive. Indeed, the severity of authorized techniques spawned the use of additional methods, including exacerbation of pre-existing injuries, beatings, rape and other forms of sexual assault, and use of electric shock.¹⁵⁹

No documentary evidence has been found to indicate that any of these additional methods were specifically authorized. Nevertheless, an environment of

pervasive dehumanization, degradation, and infliction of violence on detainees no doubt encouraged these more extreme abuses, and they may have been further encouraged by General Sanchez's memo itself, which noted that, "It is important that interrogators be provided with reasonable latitude to vary techniques depending on the detainee's culture, strengths, weaknesses, environment, extent of training in resistance techniques as well as the urgency of obtaining information that the detainee is believed to have."¹⁶⁰

General Sanchez's memo setting out methods of interrogation the U.S. military command deemed acceptable anticipated a significant role for medical personnel in authorizing certain techniques to be used in individual cases. It stated that detainees should be medically evaluated as "suitable," "considering all techniques to be used in combination,"¹⁶¹ which would require medical personnel to be intimately involved in reviewing each interrogation plan. The memo also stated that medical personnel would be expected to specifically review plans involving isolation.

Detainee interviews, official accounts, and the Army Surgeon General's survey confirm that clinical medical personnel were engaged in various aspects of interrogation and other security functions in Iraq, though the Task Force has not seen any guidance beyond the general statement in General Sanchez's memo to describe their role. The Army Surgeon General's survey, which covered the period of the most pervasive detainee abuse, from 2002 to 2004, reported that medical personnel were required, among other duties, to "perform a variety of detainee security roles."¹⁶² In Afghanistan, these included rectal and genital examinations for weapons, though these were later discontinued.¹⁶³ Colonel Thomas Pappas, who commanded the 205th Military Intelligence Brigade in Iraq and was responsible for interrogation at Abu Ghraib, filed a sworn statement that physicians monitored interrogations and psychiatrists signed off on interrogation plans involving sleep deprivation.¹⁶⁴

The Surgeon General's survey also found that medical care undertaken in connection with interrogation was not documented consistently, and medical personnel were not clear as to whether or not they had the authority to stop an interrogation if a detainee required medical care during it.¹⁶⁵ Medical personnel in Iraq acknowledged that medical care was denied or delayed so that interrogation could continue.¹⁶⁶ A non-physician medic reported that optometry care for detainees was contingent on cooperation with—and managed by—interrogators.¹⁶⁷ According to the report, training in the handling of medical records and for abuse reporting was largely absent. Independent clinical assessments of detainees held in Iraq reveal severe physical and mental health deterioration as a result of their detention.¹⁶⁸

The Surgeon General's survey also indicates that some non-BSCT medical personnel¹⁶⁹ were directly involved on an ad hoc basis in interrogation in Iraq. The survey reports that 7 of 41 medical personnel who served in level I or II facilities (i.e., field-based medical units, excluding hospitals) in Afghanistan (17 percent) and 48 of 495 of such personnel who served in Iraq (10 percent) acknowledged being present during an interrogation.¹⁷⁰ The survey did not inquire as to what roles they played, nor did it provide a breakdown of which type of medical personnel were present in interrogations. According to the report, only a handful of non-BSCT medical personnel participated in interrogation, but that finding is misleading as it is based on a definition of participation used by the Surgeon General that excludes assisting in developing the interrogation plan, observing interrogations from inside or outside the interrogation room, or being present during an interrogation.¹⁷¹

The presence of medical personnel in interrogations is confirmed by detainee accounts. Some detainees reported instances where medical personnel refused them treatment during torture or provided medical care and the interrogation continued. One former detainee told human rights investigators that during his initial interrogation at Baghdad airport someone was present to monitor his heart and blood pressure. The detainee was suspended in the air, which caused his arm to dislocate. He reported that one of the medical personnel put his arm back in its place and then informed the interrogators they could continue.¹⁷²

A medic (army-non-physician medical technician) who served at both Guantánamo and Abu Ghraib acknowledged participating directly in abuse as part of the interrogation process, including intimidating and hog-tying detainees, and refusing care to them.¹⁷³ According to his interview with a journalist:

*[He] was asked to attend to the detainees who were being abused. He'd find them dehydrated, wrists bleeding from too-tight handcuffs, ankles severely swollen from forced standing, and with joints dislocated from stress positions. Some had been pepper-sprayed and hit with non-lethal rounds. Andy and other medics used their ambulances and litters to transport detainees who were too injured to walk to and from interrogation rooms. .*¹⁷⁴

Guantánamo

At Guantánamo, the command placed a high priority on clinical care, establishing a well-equipped hospital. In addition, medical staff there sought and took advice from the ICRC about medical issues.¹⁷⁵ Physicians were also brought in from the U.S. Centers for Disease Control and elsewhere to consult on tuberculosis, mental

health, malaria, and other medical care issues. In a report in 2004, the ICRC stated that medical care was generally of good quality. Two studies based on interviews with former detainees found that while many detainees criticized the availability of medical care, a sizable minority of detainees were generally satisfied with the medical care they received.¹⁷⁶ The Army Medical Command issued fairly detailed guidance for detainee medical care in 2005 (and revised it in 2007) that stressed cultural and religious sensitivity, respect for the detainee, and a standard of medical care equivalent to that offered to American soldiers.¹⁷⁷ A report issued in early 2009 by Admiral Patrick Walsh as part of an overall review of conditions at Guantánamo found the medical staff to be professional and dedicated, and that care offered was of high quality and determined exclusively on the basis of medical need.¹⁷⁸ That report has been criticized for its methods, including the lack of any independent investigation.¹⁷⁹ We address some of the Task Force's concerns about the report later in this chapter and in chapter 3.

According to the DoD, because of the separation of clinical and intelligence functions at Guantánamo, physicians and other medical personnel not assigned to BSCTs did not evaluate detainees to ascertain vulnerabilities for use in interrogation, consult on interrogation strategy, or observe interrogations for the purpose of advancing intelligence.

Medical personnel including physicians did treat detainees during periods of interrogation. Details of their treatments are described in a previously secret log of the interrogation of Mohammad al-Qahtani at Guantánamo Bay (ORCON log) reported by *Time* magazine in March 2009.¹⁸⁰ According to *Time*, the DoD stated that the log was accurate.¹⁸¹ During the interrogation, medical personnel attended to numerous medical problems, including efforts to maintain hydration and testing for kidney function during attempted hunger strikes that were accompanied by the detainee's intermittent refusals to drink fluids. More than two-thirds of the visits were provided by non-physician, enlisted personnel (corpsmen and medics). A physician saw al-Qahtani 14 times to attend to a variety of medical problems and situations needing a physician's attention and discussed al-Qahtani's condition by phone with corpsmen and gave instructions on another date. The log notes that on the second day, at 1800 hours, medical personnel checked vital signs and determined that the detainee needed to be hydrated. At 1810, the detainee was given two bags of intravenous fluids. At 1845, the log notes, "Medical doctor arrives to evaluate detainee to ensure he is physically able to continue." There is no way to know from the log if this was the statement of the doctor or the interpretation of the interrogator log keeper.

An episode of bradycardia (low heart rate) required al-Qahtani to be hospitalized for two days, during which he received a CT scan of the head and an

ultrasound study of a swollen leg reviewed by a radiologist flown in to the naval base. Both were reported to have been normal. He received intravenous fluids, including correction of low serum potassium, and was observed at the hospital over the two days with ongoing ECG (heart) monitoring. After discharge he was returned to the detention center. Four days later, his heart rate was again noted to be low by a corpsman, who called a doctor, and was told to repeat the vital signs in an hour. The repeated heart rate was higher but still slow. This was reported by the corpsman to the doctor by telephone and, as interpreted and recorded by an interrogator keeping a log, the doctor said to the corpsman that "operations could continue since there had been no significant change..." It was "noted [that] historically the detainee's pulse sometimes drops into the 40s in the evenings." There is no way to know from the log if these statements are the actual words of the doctor on the telephone or if they are those of the corpsman and/or the interrogator keeping the log. The log of the interrogation does not include any entries indicating whether or not interrogators called in medical personnel, including the doctors; nor are there entries indicating whether or not interrogators discussed the detainee's condition with medical personnel, including the doctors. There are no log entries describing or indicating specific directions by medical personnel regarding the continuation of interrogation procedures. The log indicates that the interrogations continued following the evaluation of the detainee's fitness by the physician.

The DoD Inspector General has confirmed that detainees who experienced "serious mental health conditions" and were treated with psychoactive medications were subjected to further interrogation.¹⁸² The Inspector General's report did not consider whether the psychotic and other severe symptoms in these cases were themselves the product of interrogation methods used, but FBI reports and independent evaluations show that to be the case in some instances.¹⁸³

The medications given to detainees suffering mental health conditions were sometimes administered involuntarily, leading some detainees to believe they were being drugged for interrogation purposes.¹⁸⁴ Although the U.S. Supreme Court has determined that involuntary medication of prisoners is permissible if it is in the medical interest of the prisoner and certain procedures are followed,¹⁸⁵ the Task Force has not seen any evidence dated before 2006 as to whether or not such standards were followed—or indeed whether there were any standards or guidelines for involuntary treatment of detainees at the time. Detainee accounts and the Inspector General's report reveal that involuntary treatment with psychoactive medications was not uncommon.¹⁸⁶ In 2006, the Assistant Secretary of Defense for Health Affairs issued an instruction that involuntary treatment must be carried out under standards similar to those applied in the Armed Forces.¹⁸⁷

Medical personnel committed many acts of omission, but the most pervasive of these acts of omission that the Task Force was able to ascertain involve mental health. Conditions of confinement, absence of due process, uncertainty about the possibility of release, restriction on lawyer visits, and use of isolation and other forms of psychological manipulation, along with interrogation methods designed explicitly to induce anxiety, stress, and helplessness, took an enormous toll on detainees' mental health. Even when the abusiveness of interrogation declined in 2006, the ongoing and extensive use of isolation, which is well-known to lead to severe mental distress and deterioration, along with indefinite detention, continued to severely impact detainees' mental health.¹⁸⁸

There is evidence that some individuals experienced what appear to be psychotic episodes as a result of abuses committed against them. An FBI agent witnessing a particularly brutal interrogation in late 2002 at Guantánamo noted that the detainee "was evidencing behavior consistent with extreme psychological trauma (talking to non-existent people, reporting hearing voices, crouching in a corner of the cell covered with a sheet for hours on end)."¹⁸⁹ Independent psychiatric evaluations of detainees have also drawn connections between treatment in detention and onset of psychotic and other forms of severe mental illness.¹⁹⁰

In 2003, the Army Surgeon General asked a psychiatric consultant, Dr. Daryl Matthews, to assess mental health issues at Guantánamo after an epidemic of 350 acts of self-injury, including 120 "hanging gestures" in a single year.¹⁹¹ In response, authorities created a special behavioral health unit that conducts evaluations and provides supportive psychotherapy, medication management, suicide prevention education, and assessments of hunger strikers. Detention and interrogation practices, however, appear to have overwhelmed the unit's initiatives. In June 2004, an ICRC medical report found the existence of psychological torture at Guantánamo, resulting in increased incidence of mental illness among detainees.¹⁹²

Detainee accounts of their incarceration show constant despair and mental suffering. As of the date of this report, six detainees have reportedly committed suicide since Guantánamo opened in 2002, although some have questioned whether three of these deaths were homicides.¹⁹³ Adnan Farhan Abdul Latif, who died at Guantánamo in September 2012, has not been classified a suicide, but he had a history of depression and made several prior suicide attempts. He had been held in solitary confinement, was frequently restrained through the use of hand and body cuffs, and had gone on hunger strikes.¹⁹⁴

One investigation revealed that 18 lawyers for detainees held at Guantánamo reported that their clients' health seriously deteriorated at the facility.¹⁹⁵

Another study, which consisted of in-depth evaluations of 11 former detainees from Guantánamo and Iraq by experts in the rehabilitation of survivors of torture, revealed that all but one suffered serious and enduring anxiety, depression, and post-traumatic stress disorder, often characterized by ongoing nightmares, inability to concentrate, and significant deterioration in social functioning. The evaluators attributed these symptoms to the detainees' experience in confinement.¹⁹⁶ These findings are corroborated by proxy medical examinations¹⁹⁷ and accounts of lawyers who have had contact with detainees who suffer anxiety, depression, and even psychotic symptoms as a result of long-term isolation and other conditions of confinement.¹⁹⁸

The DoD has discounted the seriousness of the mental health impact of its detention practices. Although it denied that most detainees were being kept in solitary confinement because they could yell across cells and talk during short periods of recreation, a 2008 study found that a majority of detainees were locked in their cells for 22 or more hours a day in conditions of deprivation even more draconian than typical in a super-maximum-security prison.¹⁹⁹

Admiral Walsh's report states that, according to a provider on the behavioral health unit, in 2009 only eight percent of detainees had symptoms of mental disorders.²⁰⁰ No conclusions about the prevalence of mental disorders among detainees in 2009 can be made from this statement as it cites no data and it is clear from Admiral Walsh's report that he and his team made no independent review of the provider's assertion and did not recommend any such review.²⁰¹ The report does not address prevalence at any earlier time. The DoD has so far rejected requests by outside groups to conduct a review of the mental and physical health of detainees. The Task Force believes such a review should be an element of the comprehensive investigation we recommend.

The disparity between government reports of mental health among detainees and the observations of outsiders may be explained in part by diagnostic practices at Guantánamo. A study conducted by two members of the Task Force of medical records obtained by detainees through their lawyers, shows evidence that physicians and psychologists did not examine the relationship between the torture and cruel, inhuman, or degrading treatment detainees were experiencing and their deteriorating mental health.²⁰² Some physicians and nurses engaged in clinical care may not have been aware of the interrogation practices and conditions of confinement to which some detainees were subjected. The medical records available and other evidence suggest that in at least some cases clinicians failed to inquire into the detention-related sources of injuries and distress, and in others, when they did see a connection, failed to take action to stop the abuse.

The study of available medical records, client affidavits, attorney-client notes, and summaries of medical conditions of nine detainees at Guantánamo, shows that all of the detainees reported to clinicians that they had been tortured. Many had been treated for various medical complaints, and in three cases, the detainee had suffered a physical injury—such as contusions, bone fractures, lacerations, peripheral nerve damage, or sciatica—that was consistent with torture. Yet in none of the cases is there an indication in the medical record of an evaluation of the cause of the injuries. None of the nine detainees had reported a prior psychiatric history, but in six cases, mental health symptoms including suicidal ideation, depression, or audiovisual hallucinations were serious enough that the individuals were referred for mental health evaluation. In none of the cases, however, was a diagnosis of post-traumatic stress disorder made by the Guantánamo clinician, even though independent reviews found the symptoms were consistent with that diagnosis.²⁰³ Instead, the detainees were diagnosed with adjustment disorder, borderline personality disorder, or depression. In some cases the symptoms were attributed to the routine stressors of confinement. One detainee was told, “You need to relax when guards are being more aggressive.”

Other reports show that in some cases, senior psychiatrists dismissed the idea that conditions at Guantánamo could have anything to do with depression among detainees.²⁰⁴ In still others, detainee reports of abusive interrogation were not found reflected in medical records.²⁰⁵ Dr. Matthews, the psychiatric consultant, said he was actively misled by the command about interrogation and conditions of confinement.²⁰⁶

Some medical personnel commented on the consequences of isolation and interrogation practices. Moazzem Begg, a British detainee held by the U.S. in Afghanistan and then in Guantánamo until his release in early 2005, reported interactions with a psychiatrist who visited him periodically on account of his depression and severe anxiety attacks, which he attributed to his lengthy time in solitary confinement. Over time he developed a relationship with the psychiatrist, and she told him that there were people in the prison who had been locked in isolation and lost touch with time, reason, and in some cases, reality. Some started talking to themselves.²⁰⁷

Where medical personnel identified severe physical or mental health impacts of interrogation and confinement practices on a detainee, however, they appear to have been powerless to intervene on behalf of their patient because of policies and practices at Guantánamo. In one case, revealed in medical records and interviews with a former Guantánamo detainee, the detainee started exhibiting psychotic symptoms and made multiple suicide attempts, including ingesting two ice packs containing ammonium chloride. Clinicians

observed that his deterioration seemed exacerbated by his isolation and loneliness, expressed in repeated begging to be housed with someone who spoke his language. On October 28, 2002, the psychiatric staff made a note in the file about why they could not help with this request: “Informed him that psych had no control over that and told him to ask his interrogator to have him moved.”²⁰⁸ Under procedures then in place, moreover, a detainee with “psychological issues preventing his effective assimilation” was ineligible for being housed in a medium-security, communal setting, leading to his placement in a unit where he would be locked in his cell for 20 hours a day.²⁰⁹ The Task Force notes that responding to “psychological issues” with further isolation can exacerbate the mental health deterioration the detainee suffers.

Clinicians’ apparent powerlessness to alter the conditions of detainees’ confinement extended to physical care. Doctors prescribed more exercise for one detainee whose muscles were atrophying, but instead the prisoner was moved to a cell where for 18 months he was kept in isolation and denied exercise.²¹⁰ Officials have insisted that medical care was never denied for intelligence or security reasons, or to induce cooperation, but these and other reports suggest otherwise.²¹¹

In addition, the quality of medical care available to detainees was compromised because of the severe distrust they developed of the medical staff, in part as a result of the involvement of psychologists and psychiatrists in interrogation. Separation of clinical and intelligence functions, including the rule that behavioral science consultants could not wear insignia indicating medical status, may have seemed to commanders and the civilian leadership to be a means of preserving detainees’ willingness to place trust in the medical staff. But many detainees were not persuaded. They were aware of the participation of psychologists in interrogation. Many of them suspected, and in some cases had good reason to believe, that personal information that could only have been obtained in the course of their medical treatment was obtained by interrogators. In 2004, the ICRC reported that detainees did not seek mental health care for fear the information would be passed on to interrogators.²¹²

As described in detail in chapter 3, detainees’ trust was also undermined by medical supervision of forced feeding to break hunger strikes, which by 2006 included routine use of restraint chairs.

Detainees’ trust was compromised also by the security functions health professionals performed, including routine body cavity searches and sedation of prisoners for security purposes. The DoD has ended health professional participation in body cavity searches, but may continue to permit the use of sedatives for transport of detainees²¹³ and chemical restraints for security purposes.²¹⁴ The Task Force could not determine whether physicians or other

medical personnel wrote orders for sedatives or whether the administration of medication was protocol-driven. In either case, such practices are incompatible with ethical standards in the criminal justice context. The American Medical Association's code of ethics permits court-approved forcible treatment of a prisoner only if it is "therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control."²¹⁵ Similarly, the National Commission on Correctional Health Care, which sets standards for prison and jail medical treatment in the United States, prohibits the use of medication "simply to control behavior," instead permitting it only in emergencies, to prevent harm "when an inmate is dangerous to self or others due to a medical or mental illness."²¹⁶

Questions have arisen about the unexplained administration of an anti-malaria drug with neuropsychiatric side effects to detainees at Guantánamo, including whether there were intelligence or security reasons rather than medical reasons for doing so.²¹⁷ As the conduct of a member of the Task Force has been questioned on this subject, the Task Force does not address the matter here, but urges that the circumstances of the use of mefloquine, including the reasons for choosing it, be addressed as part of the full investigation of medical practices we recommend.

The clinical practices at Guantánamo, taken together, not only violate professional obligations and domestic and international standards of medical care for prisoners and detainees, but may well have compromised the ability of conscientious doctors, nurses, psychologists, and other medical personnel to provide quality care to detainees. These practices may also explain the inconsistent reports of detainees about the medical care they received, with some citing treatment by caring staff, and others citing delays and obstruction in receiving care, apparent indifference to their medical needs, brutality in force-feeding, and the use of information revealed in the course of medical treatment for interrogation purposes. The Task Force concludes that intelligence- and security-driven practices impeded quality medical care.

Abuse reporting and accountability for health professionals

Despite many requests from human rights organizations, to the Task Force's knowledge, no internal or independent investigation of the conduct of military and intelligence agency physicians, psychologists, and other medical personnel have ever been conducted.²¹⁸ The only specific review of practices

by health professionals, in addition to the investigation on the use of drugs for interrogation mentioned earlier, was a survey conducted by the Army Surgeon General in 2004 and 2005 that did not purport to be an investigation. As a result of internal complaints about CIA interrogation practices, as we've seen, the CIA Inspector General completed a review of interrogation practices in the agency's secret detention facilities.²¹⁹ This report, however, did nothing to restrict the use of forms of torture and cruel, inhuman, or degrading treatment that had been approved by the Department of Justice and in fact led to greater involvement of physicians and other health professionals in torture.

Because of their clinical roles, medical personnel are often in the best position to identify instances of abuse. They have opportunities to hear about abuse directly from detainees in a relatively safe setting and can examine them to ascertain whether their claims are consistent with medical and psychological signs and symptoms. Their clinical examinations can also identify the possible existence of abuse in instances where the detainee is fearful of reporting. Additionally, because they have the opportunity to raise concerns, through the Surgeon General of their service as well as through the base commander, health professionals have greater opportunities for protection from the retaliation that other soldiers suffer for reporting abuse.²²⁰ This combination of intimate contact with detainees, capacity to assess medical evidence of torture, and relative insulation from the pressures on guards and interrogators not to "snitch" on fellow soldiers, should put health professionals in a unique position to protect the human rights of detainees and uphold their own ethical obligations.

As discussed in chapter 2, military medical personnel, like other soldiers, are required to report violations of the laws of war.²²¹ However, during the period when the most intense abuses were committed against detainees in Guantánamo, Iraq, and Afghanistan, from 2001-2004, no rules specifically applicable to abuse reporting by military health professionals existed in the military.²²²

Medical personnel identifying and reporting abuse was rare in the period before specific instructions were issued on medical personnel reporting. The 2004-2005 Surgeon General's survey of medical personnel who served in Afghanistan, Iraq, and at Guantánamo showed that of 60 medical personnel assigned to detention operations in Afghanistan, only one claimed to have observed abuse or had an allegation of abuse reported to him or her.²²³ Seven medical personnel interviewed for Admiral Church's 2006 report stated that they had seen no detainee abuse.²²⁴ At Guantánamo, no previously deployed and only two currently deployed medical personnel surveyed claimed to be aware of any abuse.²²⁵ It should be noted that the Surgeon General's report findings do

not differentiate among the medical personnel who reported, that is, whether they were physicians, nurses, medics, or of another occupation.

In Iraq, 72 medical personnel deployed before the survey was conducted said they had been aware of some form of abuse, and most claimed to have reported it, but this number represented a very small fraction of the number of deployed health personnel. Moreover, the majority of reports concerned shortages of supplies, not abuse of detainees.²²⁶ Where medical records from Guantanamo, Afghanistan, and Iraq did contain reported medical evidence of abuse, 70 percent of the cases do not mention any action taken in response.²²⁷

In his review of detention operations, completed in early 2005, Admiral Church noted that in Iraq, medical personnel had access to and knowledge of detention operations. The 38 medical personnel he interviewed, including 20 physicians, however, reported only four abuse incidents, and three of them involved very serious physical injury, one resulting in death and the other two involving broken ribs and severe bruises. The fourth concerned a detainee who had been roughed up during transit.²²⁸

The DoD investigations and surveys examining prisoner abuse generally take at face value statements by medical personnel that they reported abuse when they saw it. Given the high amount of abuse of detainees on record during the period covered by these reviews—generally from 2001 to early 2005—and the paucity of abuse reporting, the Task Force finds such claims highly questionable. Even the investigations themselves reveal instances of extremely serious abuse that was not reported. Major General George Fay's 2004 review of intelligence activities relating to abuse of detainees at Abu Ghraib, for example, revealed that medics had not reported abuse in very serious cases, including two instances where detainees were handcuffed uncomfortably to beds for prolonged periods. In one of the cases the detainee suffered a dislocated shoulder.²²⁹

Medical personnel also apparently failed to report abuse indicated by deaths of detainees. A report by Admiral Church identified two instances of detainees held at Bagram in Afghanistan who died while shackled in a standing position and being beaten. In both cases, physicians who examined the individuals reported no evidence of bruising. Autopsies, however, revealed blunt force injuries to the detainees' legs, with muscle injuries so severe in one case that a leg amputation would have been required had the detainee survived. Admiral Church reported that the local physicians "may have misrepresented" the extent of the injuries, either consciously or because of an inadequate examination.²³⁰ Admiral Church expressed similar concerns regarding whether physicians failed to disclose or even misrepresented injuries that led to the death of detainees at Abu Ghraib in Iraq. In one case, a detainee slumped over and died

during interrogation. An autopsy found broken ribs that could have compromised respiration. Hooding may also have contributed to his death.²³¹

Military autopsy reports of detainee deaths, conducted by the Armed Forces Institute of Pathology, were generally done professionally, but in many cases the pathologist was not supplied with and did not inquire about information germane to the circumstances surrounding the detainee's death. In some cases the pathologist also failed to inquire about injuries to bones or ligaments, or whether sexual abuse had taken place.²³² A review of autopsy reports for 29 prisoners who died in U.S. custody in Iraq or Afghanistan from 2002 to 2005 found that while the reports supported the causes of death cited, they omitted critical contextual details, including events and conditions leading to death.²³³ In one case, a pathologist noted bruises on a prisoner's abdomen, blood contusions, and free blood in the peritoneum, but the death certificate simply noted that the manner of death was undetermined.²³⁴

Since the Abu Ghraib DoD investigations and the Surgeon General's survey, there has been no data available to the Task Force about the extent of abuse reporting by medical personnel in military detention facilities overseas. As discussed in chapter 2, however, the Task Force has concerns as to whether abuse reporting procedures put in place by the DoD are sufficient to protect the human rights of detainees.

The impact of torture and cruel, inhuman, or degrading treatment on detainees

There is extensive evidence of the immediate and long-term impact of torture and cruel, inhuman, and degrading treatment inflicted by U.S. military personnel on individuals in military custody, as apparent in accounts of men who have an opportunity to speak about their experiences (and in some cases be medically examined) and in documents released under the Freedom of Information Act or through U.S. court proceedings. No similar information exists for CIA detainees because none of those detainees have been released and they and their lawyers are prohibited by the U.S. government from publicly disclosing methods of interrogation or their effects on the detainees. We do, however, have some knowledge about 14 of these so-called high-value detainees from a report of interviews with them by the ICRC after their transfer to Guantánamo Bay in 2006. That report was leaked to the press.

In assessing impact, it is important to understand that enhanced and other abusive interrogation methods were not inflicted one at a time. Rather, detainees

were subjected to many of them continuously and in combination over weeks or months.²³⁵ Many detainees lived in conditions of confinement that included isolation, cold temperatures, loud noise, and sleep deprivation. As a result, the effects stem not from discrete acts inflicted at a moment in time but from an ongoing regime.

According to the ICRC interviews, individuals in CIA custody were kept in continuous solitary confinement for periods ranging from 16 months to four years.²³⁶ Even their communication with custodians was extremely limited. The detainees were subjected to multiple instances of techniques from among the following: waterboarding, prolonged standing stress positions for up to three days continuously and two to three months intermittently, body-slammings against walls, beating and kicking, nudity for weeks at a time, confinement in a box, sleep deprivation, exposure to cold temperatures, prolonged shackling of hands, threats to the detainee and his family, forced shaving, and deprivation of solid food.

The interviews focused more on what was done to them than on the pain and suffering it brought, but their descriptions of being beaten, slammed against walls, waterboarded, and otherwise brutalized leave little doubt of the pain and terror these techniques brought about.

Abu Zubaydah, whose interrogation occasioned the first Justice Department approval, described his experience of waterboarding and part of its aftermath to the ICRC: "I struggled without success to breathe. I thought I was going to die. I lost control of my urine. Since then I still lose control of my urine when under stress."²³⁷ In the time between waterboard sessions, Zubaydah was subjected to slamming against a wall, sleep deprivation, loud music, and confinement in a box. He described how being confined in the box without the ability to sit upright created "stress on my legs that held in this position meant that my wounds both in the leg and stomach became very painful."²³⁸ During periods when he was not in a box he was kept with a hood over his head. Also, notwithstanding the classified nature of what happened to Zubaydah, information on the impact of his torture leaked into the public domain. According to that information, he suffered permanent brain damage and seizures, blinding headaches, physical impairment, and amnesia.²³⁹ Another detainee in CIA custody described his treatment while being held in Kabul after arrest: "I was punched and slapped in the face and on the back to the extent that I was bleeding. While having a rope round my neck and being tied to a pillow my head was banged to the pillar repeatedly."²⁴⁰

The record is more extensive concerning the experiences of men held in military custody, including reports from the detainees themselves, their lawyers,

and independent medical evaluations.²⁴¹ In one study, 11 former detainees, four of whom had initially been held in Afghanistan and were then transferred to Guantánamo, and the remainder of whom were detained in Iraq, were interviewed over two days and agreed to physical and mental health evaluations. Although not a random sample, the findings are revealing. Most of the men were severely beaten when arrested and then subjected to various combinations of isolation, forced nakedness, stress positions, cold temperatures, sleep deprivation, humiliation, and growling dogs. They reported that beatings on the head and neck, stomach, and genitals while held in Afghanistan or Iraq led to excruciating pain as well as bruising and swelling.²⁴² One man described how he was beaten so severely during an interrogation in Bagram that he lost consciousness and subsequently required surgery. Soon after the surgery he was transferred to Kandahar, and though weak, he was hooded and shackled, with his knees taped together in a kneeling position while tied to the floor.²⁴³ A number of other detainees also reported losing consciousness from beatings. Suspensions—one man held in Iraq was suspended ten times—led to severe muscle and joint pain, even dislocations. Men brought to Guantánamo reported that they had experienced very painful swelling and bruising from use of handcuffs and on some occasions from beatings they received. Another detainee recalled suffering from nausea and vomiting and saw blood in his urine as a result of his treatment during initial detention at Guantánamo. Medical records at Guantánamo show that one detainee had a seizure during an interrogation.

The pain detainees suffered has endured long after release. Six of 11 men in a Physicians for Human Rights study experienced chronic headaches. The study also found evidence of chronic musculoskeletal pain from suspensions, other stress positions, and beatings. This finding is consistent with the results of another study from the University of California, Berkeley, of 62 detainees released from Guantánamo, which found that for many former detainees, the legacy of Guantánamo was ongoing pain in their wrists, knees, backs, and ankles.²⁴⁴

The mental health consequences of interrogation and detention practices were both acute and long-lasting, likely a product of the deliberate strategy of degradation and inducement of fear, anxiety, and dread, as described above.²⁴⁵ The Berkeley study found that two-thirds of the people interviewed experienced serious emotional difficulties from memories of violence, extreme temperatures, and stress positions. Many of them had difficulty re-establishing relationships with their families and most were unemployed and pessimistic about their economic future.²⁴⁶ The Physicians for Human Rights study found that all but one of the individuals evaluated suffer from severe mental health

problems, such as anxiety, depression, and post-traumatic stress disorder, the latter including intrusive recollections of trauma suffered in detention as well as avoidance and emotional numbing behavior. While taking into account their experiences in war-torn countries and, for four of them, evidence of a prior history of mental health problems, the clinicians nonetheless attributed these conditions to experiences in detention.²⁴⁷

Organizational structures and policies that directed the role of health professionals in detainee abuse

WHAT LED HEALTH PROFESSIONALS to participate in—or even to be present during—torture and cruel, inhuman, or degrading treatment of detainees in the face of firm ethical standards prohibiting such participation? To explain such behavior, scholars have cited a range of social, cultural, organizational, and psychological factors, including (a) the difficulty of resisting complicity in what Robert Lifton calls an “atrocious-producing situation,” (b) the high social and professional costs of resisting command expectations, (c) the natural receptivity of individuals in military and intelligence organizations to admonitions to protect national security and fulfill the organization’s mission, (d) traditions of conformity to authority within the medical profession, (e) reinforcement of ideas that detainees were trained in resistance techniques and thus would only provide information through non-traditional means of interrogation, and (f) the foreignness of the detainees to many Americans.¹ These factors may have both psychological and sociological force in explaining the unwillingness of medical personnel to challenge expectations or resist demands made of them.

The Task Force focused its attention on another set of factors: the military and intelligence-agency practices—policies, rules, procedures, and expectations—that led to participation of health professionals in torture and cruel, inhuman, or degrading treatment. These practices included the manipulation of ethical and professional standards to enable health professionals to rationalize their participation in abuse, the expectation that health professionals would not resist policies and procedures that would lead them to share medical and psychological information about detainees with interrogators, abuse reporting procedures and instructions that fall short of international standards, and the exclusion of interrogation-related practices from internal health professionals’ accountability mechanisms.

The U.S. military has made some reforms, especially in the promulgation of clinical guidelines for detainee treatment and, in 2012, the creation of an ethics

review board at Guantánamo, but many of the most important institutional structures and policies that formed the bases for health professional participation in torture and cruel, inhuman, or degrading treatment in the military have in recent years only been reinforced. The Behavioral Science Consultation Teams (BSCTs) have been institutionalized, the combatant role of their members made official policy, and their role in detention operations and conditions of confinement remains in place. As we explain in the pages that follow, some of these policies may even increase the likelihood that physicians, psychologists, and other medical personnel become complicit or active participants in human rights or ethical violations against detainees. The Department of Defense (DoD) interpretations of ethical standards rationalize interrogation roles for physicians and psychologists. Finally, while the DoD has developed detailed credentialing and quality assurance procedures for licensed health professionals, those procedures lack provisions for reviewing compliance with professional responsibilities toward detainees or disciplining health professionals who participate in abuse of detainees.

Unless otherwise indicated, this chapter pertains exclusively to the DoD. The Task Force has no information on the CIA since the issuance of a CIA Inspector General's report in 2004, which far from removing health professionals from interrogation, increased their role and led to even greater involvement in torture than previously. In 2009, however, the CIA was removed from the business of detaining alleged terrorists.

The undermining of medical ethics in military and intelligence practice

As noted in this report's introduction, health professional associations throughout the world have established ethical standards for doctors, nurses, and psychologists who work in prison and detention facilities, all derived from duties not to harm (non-maleficence) and to promote well-being (beneficence). These standards not only promote ethical behavior and reinforce the health practitioner's commitment to protect the well-being of patients or others subject to medical or psychological evaluation, but they empower health professionals to resist demands from commanders to participate in abuse of detainees. The role of health professionals in complying with ethical responsibilities toward prisoners is considered so important worldwide that the United Nations has promulgated professional standards on the subject.² There is broad consensus within the field of military medicine, too, that the ethical principle

of non-maleficence applies to military health professionals assigned to prisons, especially in the context of torture.³

Under domestic and international standards, physicians and other health professionals working in prisons and detention centers are permitted to conduct evaluations to determine whether a prisoner or detainee has a mental or physical condition that would preclude interrogation. But they are forbidden to subordinate the health interests and well-being of prisoners to the security, intelligence, political, or institutional interests of the facility. According to the UN Principles of Medical Ethics, "It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health."⁴

At the heart of the health professional's obligation toward individuals in custody is the responsibility not to engage or be complicit, actively or passively, in torture or cruel, inhuman, or degrading treatment or punishment.⁵ This includes taking any action, however indirect, that would enable torture either to begin or to continue. In 1975, the World Medical Association condemned the participation of physicians in torture in any manner, including being present when torture takes place or treating individuals so that torture can continue.⁶ In 1984, the American Psychological Association and the American Psychiatric Association issued a joint statement condemning the use of torture.⁷ In 1992, the American College of Physicians adopted a position similar to the World Medical Association's and in 1995 issued a detailed policy on the role of physicians and the medical profession in the prevention of international torture.⁸ The American Medical Association issued an ethics opinion in 1999 stating that a physician may not participate in torture, be present when torture is conducted or threatened, or provide evaluation or treatment so that torture can continue.⁹

In the wake of the Abu Ghraib scandal and revelations about medical involvement in abuse at Guantánamo, the DoD and the Army Medical Command established more explicit standards of conduct for treatment of detainees. The Assistant Secretary of Defense for Health Affairs issued a directive stating that, "Health care personnel charged with the medical care of detainees have a duty to protect detainees' physical and mental health and provide appropriate treatment for disease. To the extent practicable, treatment of detainees should be guided by professional judgments and standards similar to those applied to personnel of the U.S. Armed Forces."¹⁰ It prohibited clinicians from taking any action that was not for the purpose of evaluating, protecting, or improving detainees' physical and mental health, and required maintenance of accurate and complete medical records.¹¹ A subsequent U.S. Army manual on medical support for detainee oper-

ations fleshed out these ethical duties, setting out obligations regarding standards of care, preferences for patient consent to treatment (with exceptions), confidentiality of medical records, treatment with respect and dignity, abuse reporting, and prohibition on security-based body-cavity searches.¹²

At the same time, however, the CIA and DoD undermined these standards by reinterpreting and rewriting them for military and intelligence medical personnel. They contravened otherwise strong ethical requirements by creating exceptions to them. The evidence suggests these actions were part of the process of engaging medical personnel in interrogation whose objective, according to the CIA Office of Medical Services (OMS), was to “psychologically ‘dislocate’ the detainee, maximize his feeling of vulnerability, and reduce or eliminate his will to resist our efforts to obtain critical intelligence.”¹³

The agencies reshaped ethical standards in three ways: (1) excluding individuals acting as behavioral science consultants from some key ethical requirements applicable to their profession, (2) conflating ethical requirements with a mere obligation to obey the law, and (3) characterizing health professionals on BSCTs as “safety officers” whose function includes protecting detainees as well as assisting in intelligence gathering.

EXCLUDING BEHAVIORAL SCIENCE CONSULTANTS FROM KEY ETHICAL DUTIES

In conjunction with deploying BSCTs in the planning and use of abusive interrogation methods, the military introduced a distinction between ethical standards applicable to clinical practice and those for non-clinical practice, a distinction that does not exist in the health professions. As the DoD now asserts, one key professional obligation, the duty to limit or avoid harm, is applicable only in situations where the health professional has a clinical relationship with the patient. Current military instructions state that only medical personnel “*charged with the medical care of detainees* (emphasis added) have a duty to protect detainees’ physical and mental health and provide appropriate treatment for disease.”¹⁴ Health personnel who do not provide these clinical services, the DoD asserts, only have an obligation to obey the law as it applies to detainees. The purpose of this interpretation was to exclude behavioral science consultants from the duty to protect health.

The distinction between clinical and non-clinical obligations was first asserted in 2004 by then Deputy Assistant Secretary of Defense for Health Affairs David Tornberg, who argued that when a doctor participates in interrogation, “he’s not functioning as a physician.”¹⁵ The DoD went so far as to change key words in the United Nation’s standards of medical ethics, drafting its own stan-

dards for treatment of prisoners so as to undercut the universal norm of promoting well-being and avoiding harm.¹⁶ For example, where the UN principles state that it is a contravention of medical ethics for a physician to have “any professional relationship” with a prisoner other than to evaluate or seek to improve the individual’s health, the DoD replaced the key language with the more limited phrase, “any patient-clinician relationship”¹⁷ (the DoD’s ethical obligations for behavioral science consultants are discussed in the next section).

The Pentagon’s view is universally rejected among professional organizations that establish standards for physicians. Although there may be circumstances where ethical obligations vary with role, core obligations grounded in beneficence and non-maleficence remain for all regardless of role. The obligation of physicians and psychologists not to harm the individuals they encounter in professional practice and while using professional skills is based on the role they play in society and what has been aptly described as a social contract with society.¹⁸ In effect, the DoD sought to have it both ways: it wanted to ensure that its behavioral science consultants possessed recognized professional qualifications, including a license for clinical practice in psychology or forensic psychiatry, but also excluded them from the full panoply of ethical norms that govern their professions and that they committed as licensed professionals to uphold.

When the post-9/11 involvement of U.S. health professionals in detainee abuse and the position of the DoD on ethical standards became known, medical authorities and professional medical organizations studied and rejected the DoD’s limitations on the ethical responsibilities of physicians. They made explicit their view that the duties of beneficence and non-maleficence applied to physicians engaged in interrogations, including lawful ones. They specifically noted that these interrogations often include the use of manipulation, deception, and stress-inducing tactics on the person subject to questioning, but do not constitute torture or cruel, inhuman, or degrading treatment.

The World Medical Association took up the question first. After review, it concluded that the duties to avoid and prevent harm and promote well-being are inconsistent with any action that creates discomfort for, induces stress on, deceives, or manipulates an individual where these actions have no therapeutic purpose. Accordingly, in 2005, it amended its Declaration of Tokyo, which prohibited physician participation in torture, to add that, “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.”¹⁹ American medical organizations followed suit. The same year, the American College of Physicians, composed of specialists in internal medicine and constituting the second-largest medical asso-

ciation in the United States, stressed in its medical ethics that it is unethical for a "...physician to be used as an instrument of government for the purpose of weakening the physical or mental resistance of another human being."²⁰

In 2006, the American Psychiatric Association issued a policy statement (see appendix 3, which includes relevant policy statements for all the professional associations) against psychiatrists directly participating in interrogation.²¹ One participant in the association's review explained that there were two rationales for the decision: First, interrogation is, by its very nature, coercive and deceptive, and detainees in national security interrogations conducted by military and intelligence agencies lack the ability to stop the interrogations, unlike individuals in the criminal justice system who can exercise their Miranda rights. The frequent use of false information by interrogators to elicit intelligence from detainees adds to the inappropriateness of medical participation. Second, interrogation is incompatible with psychiatrists' role as providers of treatment and healers, as it undermines trust in physicians and potentially compromises the communication essential to good medical care.²² The association rejected an alternative proposal to permit participation in interrogation so long as those interrogations were not coercive, believing that a psychiatrist who provides information for interrogation would have no way of knowing how it was used.²³ The association opined that a psychiatrist can ethically share general knowledge about interviewing techniques that could be used by interrogators, but recognized that a firm line must be drawn at using any knowledge about or providing any advice concerning the interrogation of a particular individual.

Soon thereafter, the American Medical Association issued a new ethics opinion taking the same position against physicians' direct participation in interrogation.²⁴ And in 2008, the American College of Physicians stated more specifically that, "Physicians must not conduct, participate in, monitor, or be present at interrogations, or participate in developing or evaluating interrogation strategies or techniques."²⁵

These ethical obligations apply notwithstanding conflicting legal requirements. The American Medical Association's position is unequivocal:

*Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, the law mandates unethical conduct. In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations.*²⁶

Of the professional groups, only the American Psychological Association has endorsed the idea that health professionals—in this case, behavioral science

consultants—can ethically participate in interrogation. The policy originated in a report from the association's Presidential Task Force on Psychological Ethics and National Security (PENS) and was rapidly adopted by the association.²⁷ The PENS task force, however, was far from disinterested: a majority of its members were affiliated with military or intelligence agencies and some served on BSCTs.²⁸ This irregularity leads our Task Force to defer less than we might otherwise to the decision of a professional association in setting ethical standards. Further, our review of the American Psychological Association's ethical principles leads us to conclude that the PENS position is inconsistent with the association's principles regarding the avoidance and minimization of harm, transparency, and conflicts of interest. Those principles, for example, do not make distinctions in fundamental obligations based on whether a psychologist occupies a clinical or a non-clinical role.²⁹ Instead, as stated in one of its key principles, "Psychologists must take reasonable steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable."³⁰ Far from creating differing obligations based on role, the American Psychological Association's ethical principles impose the obligation regardless of role. For example, in forensic examinations, the association has ethical standards requiring disclosure of the psychologist's role on behalf of the court or other entity and the degree to which information will not be kept confidential. These responsibilities are inconsistent, indeed incompatible, with the military requirement that a BSCT psychologist not be identified as such to detainees. The psychologist behavioral science consultant thus cannot disclose his or her role as ethically required, much less explain to the detainee the uses to which the psychological information will be put.

Although purporting to support earlier resolutions against torture, the PENS report also noted that the American Psychological Association permits psychologists to resolve conflicts between law and ethical standards in favor of the law,³¹ which in practice meant allowing participation in all the interrogation methods approved by the Department of Justice. The PENS report also asserted a responsibility, found nowhere among the American Psychological Association's ethical principles, to balance harms to individuals against national security interests: "Psychologists have a valuable and ethical role to assist in protecting our nation, other nations, and innocent civilians from harm, which will at times entail gathering information that can be used in our nation's and other nations' defense." The report claimed psychologists have a unique and "central" role to play in "ensuring that [interrogation and information-gathering] processes are safe, legal, and ethical for all participants."³²

Our Task Force notes that reconciling the intelligence interests of the state and the well-being of the detainee is impossible for an individual psychologist in the situation of interrogation. The psychologist is in no position to know the value of the information sought for national security or determine the boundaries of harm that may be imposed to support gaining the information, much less how to strike an appropriate balance between the two. At the same time, he or she should not defer to the judgments of commanders or other intelligence officials on key ethical obligations.

The American Psychological Association's adoption of the PENS report prompted a major controversy within the organization.³³ The large New York affiliate adopted a contrary position in supporting proposed state legislation that would render participation in interrogation a disciplinary offense. The association adopted more detailed ethical standards against participation in torture, including identifying certain interrogation methods, such as isolation and sensory deprivation, as forms of torture.³⁴ A member-initiated referendum declared that psychologists may not work in settings where persons are held in violation of international law or the U.S. Constitution unless on behalf of the person detained or a third party seeking to protect human rights.³⁵ The original PENS view that it is ethical for psychologists to participate in interrogations nevertheless remains official American Psychological Association policy.

Supporters of the American Psychological Association position have argued that evaluating individuals for lawful interrogation, providing advice to interrogators in individual cases, and observing and commenting on individual interrogations is different both from clinical practice and from asking questions or other direct interactions with a detainee. It is a position the Task Force takes seriously, but rejects. According to this view, these activities are akin to a forensic role, such as assessing individuals for competence, suitability for child custody, or insanity in a criminal case, all of which can also have negative consequences for the person evaluated. There may be some ethically relevant differences between forensic and clinical practice, but we believe that in both roles, the standards of beneficence, non-maleficence, disclosure, and transparency apply.

Further, interrogation differs fundamentally from forensic evaluations. Evaluations for judicial or other proceedings are for impartial determinations by decision-makers to resolve factual or legal questions, not for exploitation of a person's vulnerabilities or use in manipulation, as advising in even lawful interrogation is. Moreover, in forensic roles, the psychologist is not a participant in strategy or tactics, but an expert to aid a neutral decision-maker. In military practice, the psychologist is directly engaged in interrogation, regardless of who asks the questions; there is no distinction between advising an inter-

rogator and asking interrogation questions, as the psychologist in both cases is directly participating in the tactics used. As then-president of the American Psychiatric Association, Nada Stotland, said, "It's not the role of psychiatrists to figure out people's weaknesses and try to prey on them.... This is about the soul of a psychiatrist, which is to be dedicated to helping people and healing people."³⁶ The DoD itself has recognized the inherently harmful dimension of interrogation, which is the basis for excluding clinicians from participating in it: "Under the provisions of the Geneva Conventions, medical personnel are prohibited from engaging in acts that are considered harmful to the enemy. Therefore, medical personnel providing direct patient care for detainees will not provide assistance to detainee interrogation teams."³⁷

The standards of forensic practice recognize the centrality of practitioners' adherence to basic medical and psychological ethical standards. The preamble to the American Academy of Psychiatry and Law's ethics guidelines for the practice of forensic psychiatry, issued in 2005, for example, notes that forensic psychiatrists are "bound by the underlying ethical principles of respect for persons, honesty, justice, and social responsibility."³⁸ In cases where evaluations are done for third parties, the guidelines state that a forensic psychiatrist must indicate for whom the evaluation is being conducted and what use will be made of the information obtained. But behavioral science consultants working for the military do not show the "respect for persons" the standards require, as they are engaged in deception, exploitation, and manipulation. Indeed, deception is required by current military instructions, which state, "[behavioral science consultants] will not display recognizable patches or other designations on uniforms identifying them as health care providers or medical personnel while supporting detention operations, intelligence interrogations, or detainee debriefings so as to avoid any misperceptions of the [behavioral science consultants'] function or role."³⁹

The forensic psychiatry guidelines also take account of the "core principle" of informed consent in forensic evaluations. Although they note that court-ordered evaluations may be undertaken without consent, the psychiatrist must nevertheless seek to obtain consent. Moreover, forensic psychiatrists are instructed not to perform such evaluations on behalf of government investigators or prosecutors unless the person has had a chance to consult with counsel. For BSCTs, by contrast, consent is circumvented entirely because the role is designed to identify and exploit vulnerabilities.

In 2011, the PENS task force position was further undermined by revisions to the American Psychological Association's Specialty Guidelines for Forensic Psychology.⁴⁰ The substantive provisions of the guidelines, though not binding,

underscore why the behavioral science consultant role in interrogation is ethically untenable. First, the guidelines call for transparency and disclosure in revealing the purpose of any evaluation conducted to the person being evaluated. Disclosure may include “the purpose, nature, and anticipated use of the examination; who will have access to the information; associated limitations on privacy, confidentiality, and privilege, including who is authorized to release or access the information contained in the forensic practitioner’s records; the voluntary or involuntary nature of participation, including potential consequences of participation or non-participation.”⁴¹ These disclosures are all inconsistent with the very nature of BSCT practice, where non-disclosure and deception govern.⁴²

Second, citing the American Psychological Association’s ethical code, the guidelines warn forensic practitioners to “refrain from taking on a professional role where conflicts of interest could reasonably impair their impartiality, competence or judgment.”⁴³ It particularly warns psychologists about the need for care, and possibly delaying the examination, in situations where a person examined lacks appropriate counsel.⁴⁴ In military practice, the behavioral science consultant role is grounded in a conflict of interest, as the person is expected both to protect the detainee and advance intelligence gathering. The PENS task force recognized the conflict, but rather than concluding that it inevitably leads to an intolerable ethical breach, it urged a “delicate balance of ethical considerations.”⁴⁵

Third, engaging in the calibration of harm, which is central to the behavioral science consultant role, is unacceptable under the guidelines, all the more so when judgment is inevitably affected by a conflict of interest. The guidelines note that the duty to avoid conflicts of interest is particularly important where they “expose a person with whom a professional relationship exists to harm.”⁴⁶

In view of the clarity of the guidelines on matters central to the function of BSCTs, the Task Force believes the American Psychological Association should revise its stance on direct participation in interrogation. The Task Force also calls on the DoD not to follow the PENS standard and instead harmonize its own practice with the prevailing view of professional obligations as expressed by the medical associations. That course would require abandoning the artificial distinction in professional obligations based on clinical or non-clinical roles and, with it, the participation of health professionals in interrogation.

CONFLATING LEGAL AND ETHICAL OBLIGATIONS

In setting out the ethical obligations of medical personnel in support of enhanced interrogation, both the DoD and the CIA conflated legal standards with ethical ones. The DoD instruction on ethical standards for non-clinical

health professionals refrains from using the language of preserving well-being and avoiding harm, instead using the language of legal requirements: these health professionals have an obligation “to uphold the humane treatment of detainees and to ensure that no individual in the custody or under the physical control of the DoD, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment, in accordance with and as defined in U.S. law.”⁴⁷ All the controlling words in this formulation are not only legal in nature, but describe avoiding conduct that could result in criminal prosecution. Thus, the DoD undercuts traditional expectations of conduct for health professionals engaged in interrogation support by equating ethical conduct with the minimal requirement of abiding by criminal laws. In taking this position, which remains in place today, the DoD undercuts the standards of medical ethics for military health professionals and creates a harmful breach between civilian and military medicine.

The U.S. Army guidance on behavioral science consultants also rejects the expectation that licensed health professionals in its employ adhere to the ethical standards set by their professional associations’ ethical principles.

*The DOD requires that all military professionals perform their duties in an ethical manner, consistent with their professional ethics, although they are neither required to join nor adhere to the policies of any specific professional organization.*⁴⁸

Rather, the DoD reinterprets those requirements and then holds that participation in interrogation is ethically appropriate because of the requirement of humane treatment:

*In consideration of the safeguards including those for humane treatment of detainees, the consultative nature of the work of BSCT personnel, reporting requirements for all personnel, as well as the clear distinction between healthcare functions and behavioral science consultation, the [Office of the Surgeon General] determines that performance of behavioral science consultation duties as described herein is deemed ethical practice consistent with medical and psychological ethics.*⁴⁹

An example of this reinterpretation of professional standards is contained in the 2009 version of the BSCT guidance, where the Army Medical Command stated that notwithstanding the obligations imposed by their professional organizations, physicians who do not provide medical care could be involved in decisions about interrogating individuals “if warranted by compelling national security interests.”⁵⁰ No such exception exists. In the 2012 revision, that sen-

tence was removed, but the authorization for forensic psychiatrists to participate in BSCTs was retained as an ethically permissible means of “balancing obligations to society against those of individuals.”⁵¹ To justify this position, the Surgeon General cites the American Medical Association’s policy on medical participation in interrogation for authorization of such balancing, but in fact the policy contains no allowance for balancing obligations to the individual against those of society.⁵² A report accompanying the proposed ethical standard discusses potential balancing of interests but is not considered by the American Medical Association to be part of or a basis for interpreting the ethical standard; indeed, the report, while posted on the American Medical Association’s website, contains a disclaimer in large, bold, capital letters that it is not to be cited, reproduced, or distributed without express permission.⁵³

Psychologists, too, are affected by the conflation of legal and ethical standards, as the Army Medical Command goes beyond the PENS position and requires psychologists to adhere only to legal requirements such as humane treatment. While the PENS task force introduced the concept of balancing responsibilities to the individual against national security (as noted, a position we find faulty), it did not eschew ethical obligations of psychologists in a behavioral science role altogether.⁵⁴ The BSCT guidance, while noting that all licensed psychologists are bound by the American Psychological Association’s ethics code, states that the code pertains only to psychologists’ activities that are “part of their scientific, educational or professional roles.” It asserts that the code does not have purview “over the psychologist’s role as a Soldier, civilian, or contract employee that is unrelated to the practice of psychology.”⁵⁵

According to the BSCT guidance, behavioral science consultants are combatants, so the question arises whether the code of ethics applies at all to psychologists on BSCTs. On the one hand, the guidance concedes that the ethics code applies to psychologists in the performance of their profession. But on the other, it interprets the code to do nothing more than impose a standard of humane treatment. Thus the guidance notes that “applicable U.S. and applicable law, regulations and DoD policy require the humane treatment of all detainees, regardless of status. This tenet is completely consistent with the Ethics Code.”⁵⁶ That is an incorrect statement, as the ethics code requires far more than humane treatment, including a duty to minimize harm where it is foreseeable and avoidable, avoid conflicts of interest, and ensure transparency and consent. In a similar vein, the ethics code’s requirement to minimize harm is equated in the guidance with humane treatment of detainees. In other words, stringent ethical standards applicable to psychologists are discarded for the legal standards all soldiers must follow.

Interrogation support by BSCTs was not the only area where the DoD substituted legal standards of conduct for medical ones. In the case of medical involvement in punishment, the DoD substituted a duty only to obey domestic law for ethical obligations founded on international human rights requirements. Whereas the UN Principles of Medical Ethics prohibits certification of or participation in punishment that may adversely affect the subject’s mental health if it is not in accord with international instruments, the DoD allows certification or participation if that punishment is in accord only with U.S. law.⁵⁷

With respect to the CIA, the few (and heavily redacted) documents the Task Force has been able to review reveal that, as of 2004, the agency’s position similarly conflated adherence to criminal law with compliance with ethical obligations. Even as the CIA recognized that physicians support interrogation methods that are designed to maximize the detainees’ feelings of vulnerability and helplessness, and reduce or eliminate their will to resist, it affirmed the ethical obligations of physicians participating in the interrogations:

*All medical officers remain under the professional obligation to do no harm. [sentence redacted] Medical officers must remain cognizant at all times of their obligation to prevent “severe physical or mental pain and suffering.”*⁵⁸

The quoted language is in the original. As the DoD did, the CIA replaced ethical obligations with obedience to domestic law. The phrase “severe physical or mental pain or suffering” is taken directly from the U.S. anti-torture criminal statute⁵⁹ and means that health professionals in its employ are permitted to impose harm so long as it does not amount to legally-prohibited severe harm. The significance of the CIA’s use of the legal standard, “severe physical or mental pain or suffering,” is especially apparent in light of Justice Department opinions, shared by the OMS, that deemed mental harm to be severe only if it lasted for months or years.⁶⁰ This conflation of criminal law and ethical standards not only appeared to justify medical participation, but likely helped to induce psychologists and physicians to acquiescence in interrogation.

CREATING THE ILLUSION OF HEALTH PROFESSIONALS AS SAFETY OFFICERS

Both the military and the CIA adopted a third strategy that supported departure from professional ethical obligations: conveying to health professionals that they were present to protect the safety of the detainee, thus appealing to their training in exercising the duties of beneficence. As noted in chapter 1, from the start of the abusive interrogation program in the months after 9/11, both agen-

cies claimed to rely on physicians and psychologists to avoid undue harm to detainees through pre-interrogation medical evaluations, monitoring and in some cases intervening in interrogations, and signing off on interrogation plans using sleep deprivation or isolation. This claim contributed to their legal and policy justifications in 2002 for the use of methods of interrogation that clearly harmed detainees. It also served to justify health professionals' participation in abusive interrogation.

When reports of severe mistreatment of detainees at Guantánamo and elsewhere began to appear in the press, and complaints surfaced within the CIA about the use of waterboarding and other dangerous methods of interrogation, the DoD and CIA emphasis on the participation of health professionals as a safeguard intensified. By 2004, both the CIA and military began making explicit claims that the role of doctors and psychologists in interrogations was to protect the detainee.⁶¹ As noted in chapter 1, this role was cited by Justice Department lawyers to support their claim of the legality of enhanced interrogation methods, including waterboarding.⁶² The evidence suggests, though, that the characterization of health professionals as detainee protectors was more than a legal justification; it was also intended to convince BSCT members and CIA physicians, as well as critics, that medical and psychological personnel were acting in a traditional health professional role, looking after the well-being of detainees.

By 2004, the DoD began to characterize psychologists on BSCTs as "safety officers," a description that remains in place today. In addition to performing the "mission critical" role of advancing intelligence goals by securing information from detainees, the DoD has asserted that the behavioral science consultant's role is to ensure the protection of detainees by preventing interrogators from "behavioral drift" that could lead to what even they consider torture or other practices that would lead to severe harm to detainees.⁶³ The OMS also claimed a protective role for health professionals, stating that the use of enhanced interrogation methods is "conditional on on-site medical and psychological personnel confirming from direct detainee examination that the enhanced technique(s) is not expected to produce 'severe physical or mental pain or suffering.'"⁶⁴ As this language suggests, the CIA at once elevates the role of medical and psychological personnel in preventing detainee abuse and lowers the standard for what action against detainees is ethically tolerable—that is, they are not present to prevent any harm, but only harm that violates the law on torture and cruel, inhuman, or degrading treatment.

The record of "safety officer" practices remains scant as interrogation logs

remain classified. The Task Force is not aware of specific cases where either BSCT or CIA medical personnel intervened to prevent harmful conduct (chapter 1 describes cases where members of BSCTs encouraged acts of torture), though such cases may exist.

The Task Force's concern, like that of the World Medical Association and other entities that have looked at the claimed protective role of health professionals in interrogation, is that having a psychologist on-site during interrogations could potentially have the opposite effect to providing "safety." The health professional may either give license to interrogators to inflict harm until he or she says stop or provide interventions so that the torture can continue.⁶⁵ The Task Force also notes the contradiction between the explicit requirement of BSCTs to identify and exploit detainee vulnerabilities on the one hand and to protect these same detainees on the other. These opposite functions could only be reconciled in an environment where the threshold of what constitutes harm to the detainee—the result of conflating ethical and legal standards as described above—is so high that psychologists could believe they were serving what were otherwise inconsistent objectives. In ethical practice, moreover, there is no balancing the conflicting goals of intelligence gathering and detainee protection.

The concept of a psychologist or physician as a safety officer may have served to reassure health professionals participating in interrogation that they were acting consistently with ethical obligations. The idea of a safety officer could well have also provided a comforting rationalization for the PENS task force affirmation of psychologist participation in interrogation, as it noted that psychologists are "uniquely" suited to ensure the safety of interrogation.⁶⁶ Individual members of BSCTs, when called upon to explain their role to representatives of medical associations who visited Guantánamo, or in other venues, repeatedly cited the safety officer characterization of their role. Larry James, who headed BSCTs at Guantánamo and in Iraq, portrays his role in precisely this way, entitling his book "Fixing Hell,"⁶⁷ seeking to portray his role as ameliorating abusive practices used against detainees. His own account reveals, however, that when personally observing terribly abusive behavior by an interrogator, he did not intervene to protect the detainee, only later suggesting alternative approaches to the interrogator.

In the Task Force's view, the only way to restore the ethical integrity of health professionals in the military is to end the distinction between military and civilian ethics, affirm the centrality of obligations of non-maleficence and beneficence, and abandon standards that permit health professional participation in, monitoring of, or advice regarding interrogation.

The use of detainee medical and psychological information in military interrogation

The policy of exploiting a detainee's vulnerabilities in order to wrest potentially useful intelligence from him rendered detainee medical records a natural source of information for use in devising interrogation strategy. For health professionals, this raises concerns about the confidentiality of medical information. The duty to protect confidentiality in medical practice is not absolute, and sometimes must yield to the duty to protect the safety of identifiable third parties. The legal consequences of disclosure can be serious, including placing the patient at risk of prosecution. Even so, the claim for respect for confidentiality is strong when a breach can result in direct and significant physical or mental harm to the individual through the interrogation process.

Reflecting a strong international consensus, the World Medical Association had since 1975 held it unethical for a physician to use knowledge to facilitate the practice of torture.⁶⁸ In 2006, in response to revelations of U.S. interrogators using medical information about detainees, the World Medical Association clarified the duty, stating that, "When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information." To ensure the protection of detainees, its revised ethical standard states that "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."⁶⁹

Even in circumstances where confidentiality of information may legally and ethically be breached, physicians and psychologists have a duty not to harm. Part of that obligation is to notify the individual whose information is to be released and to disclose only the minimum information necessary to accomplish the purpose of the release.⁷⁰ Psychologists are similarly obligated to discuss with anyone with whom they have a professional relationship the limits of confidentiality and the foreseeable uses of the personal information given them.⁷¹

In addition to the individual health professionals' responsibility to maintain confidentiality of detainee medical information, it should be recognized that medical records in health care institutions are kept on file, electronically or otherwise, by the institutions. They also have a responsibility to protect confidentiality of medical records, including ensuring that records are not misused for purposes other than for health care of the patient. Many of the incidents in which interrogators accessed detainee medical information had to do with their

direct access to detention center records. Military authorities should have institutional policies, procedures, and accountability reviews that safeguard medical information from interrogators, health professionals not involved in the care of the detainees, guards, and other unauthorized detention center personnel.

In 2004, the International Committee of the Red Cross (ICRC) found that medical records at Guantánamo had become a source of information used in trying to extract intelligence from detainees.⁷² When the ICRC report on these open medical files became public in late 2004, the DoD at first denied its accuracy. However, policy at Guantánamo since 2002 had not only asserted that detainees had no right to the confidentiality of medical information, but also required medical personnel to "convey any information" concerning "the accomplishment of a military or national security mission including homeland defense" obtained "in the course of treatment" to non-medical military or "other" personnel "who have an apparent need to know the information."⁷³

The original BSCT standard operating procedure from 2002 stated that one of the "mission essential tasks" for behavioral science consultants was to "act as liaison" between the Joint Intelligence Group, which was responsible for interrogation, and the Joint Task Force, which ran Guantánamo. This function included describing "the implications of medical diagnosis and treatment for the interrogation process."⁷⁴

A senior psychologist assigned to Guantánamo in early 2003 said he was told that military, CIA, and FBI interrogators routinely demanded and obtained clinical records from the hospital treating detainees.⁷⁵ The Army Surgeon General also reported that BSCTs maintained their own database of medical information on detainees.⁷⁶ The Surgeon General reported that in Iraq, though health care providers were not required to verbally share medical information with intelligence operations, they were not prohibited from doing so even after the revelations of detainee abuse at Abu Ghraib;⁷⁷ in at least one location in Iraq, interrogators themselves held medical records.⁷⁸ The use in interrogation planning of medical information and psychological assessments obtained ostensibly for treatment purposes was widespread. As described in chapter 1, psychologists working for the CIA and for the military also assessed the psychological status of detainees in order to exploit their vulnerabilities. This included face-to-face interviews designed to obtain information potentially helpful to interrogators, personality profiling, identification of mental health conditions and diagnoses (if any), and evaluations of likely ability to resist interrogation.

After controversy erupted as a result of the ICRC report, which was leaked to the public, the DoD issued a series of ambiguous, confusing directives that purported to limit the use of medical information for interrogation purposes.

But rather than repudiating the use of medical and psychological information, the DoD continues to allow medical and psychological information about detainees to be used in interrogation, so long as it does not come from records of clinical treatment. The basic distinction in place today is that individual and institutional medical care providers may not share clinical information with interrogators, but health professionals who are members of BSCTs can perform assessments of detainees and share them with interrogators.

The first policy to make this distinction appears to have been issued in March 2005 in a standard operating procedure stating that, “neither BSCT personnel nor interrogation teams have access to medical records of detainees.”⁷⁹ It further stated that medical information provided to interrogators by the BSCT was for the purpose of alerting them to conditions that could affect the safety of the detainee during interrogation. Yet in an annex to the operating procedure, a risk assessment protocol provided that in preparing risk assessments of detainees for purposes of interrogation, the BSCTs should “provide a brief summary based on medical and other reports, interviews with medical personnel, and possibly direct observations. . . [including] a brief statement of overall medical condition provided by medical personnel,” as well as a summary of physical, cognitive, and behavioral functioning, and a psychological history encompassing information such as motivations for violent jihad travels.⁸⁰ This information is clearly related to exploitation, not protection. Medical personnel were required to “provide information necessary” as part of the assessment.⁸¹

Six months later, in September 2005, the Army Medical Command appeared to take a more unequivocal position against the use of records for interrogation: “At no time, the military police or other detention facility personnel will have access to medical records and at no time will detainees’ medical information be used during interrogation.”⁸² But the same document qualified the restriction, allowing the BSCTs to have access to medical records. It states that the behavioral science consultant “will not have access to medical records or any information about a detainee’s medical treatment except as needed to maintain safe, legal and ethical interrogations.”⁸³ Such an exception clearly swallows the rule. Moreover, the guidance allowed BSCTs to participate in the “interpretation of medical records and information”⁸⁴ so long as they are not engaged in clinical care.

In 2006, the controversy over access to medical information for use in interrogation reached the Pentagon civilian leadership, which makes policy for all the armed services. Just as the World Medical Association was in the process of clarifying the duty of confidentiality in connection with medical treatment and interrogation of prisoners and detainees, the Assistant Secretary of Defense for Health Affairs issued an instruction explicitly permitting medical records to be

used for interrogation. The instruction, which remains policy today,⁸⁵ references U.S. law, apparently a reference to HIPAA (the Health Insurance Portability and Accountability Act), which permits disclosure of medical records for any lawful law enforcement, intelligence, or national security-related activity, so long as certain procedural requirements are met.⁸⁶ The instruction warns against misuse of records, but does not state or imply that interrogation is a misuse. The instruction states that, “Detainees shall not be given cause to have incorrect expectations of privacy or confidentiality regarding their medical records and communications.”⁸⁷

As noted, a broad exception exists in HIPAA for disclosure of medical records for lawful intelligence and national security activities.⁸⁸ However, in the view of the Task Force, the law did not consider nor did it anticipate the unique confidentiality, human rights, ethical, and health care access issues arising in the context of detainee interrogation. For example, there are strong disincentives for detainees to seek health care, knowing that the information could be used in interrogation. Further, disclosure of detainee records can compromise the quality of clinical care, and create new ethical problems for health care professionals, if they have to weigh the consequences for detainees if information is included in the medical record that could be used to harm the detainee during interrogation.

The issue remains a sensitive one for the DoD. Although official policy remains the same as in 2006, with its blanket allowance of using detainee medical information for interrogation purposes, Admiral Walsh’s 2009 review of practices at Guantánamo claimed that “Behavioral Science Consultants have no access to medical records or medical information systems”⁸⁹ and that safeguards are in place to prevent such access. The 2009 BSCT guidance also states flatly that behavioral science consultants “will not have access to detainee medical records”⁹⁰ and treating psychiatrists are not permitted to share records with BSCTs.⁹¹ It did, however, permit BSCTs themselves to make their own psychological assessments of detainees.

The most recent BSCT guidance removed the unequivocal language in the 2010 version prohibiting BSCT access to medical information. Instead, it contains the ambiguous sentence, “Detainee medical information obtained from the medical team will not be used to enhance interrogations or debriefings.”⁹² It is not clear whether the term “enhance” refers to enhanced interrogation, which is now banned in the armed forces, or instead means simply to aid interrogation (medical information can be used to alert interrogators to conditions that could result in unintended harm during interrogation). Regardless of the intention, the revised guidance states, consistent with the 2006 directive, that

medical information can be used for medical purposes. It also includes new language, that “[behavioral science consultants] are permitted to use medical information within the scope of their duties in order to help maintain safety and order within a facility, or to prevent harm to a detainee.”⁹³ These include risk and threat assessments and maintaining order within the facility.

Apart from use of clinical records, BSCTs are required to conduct their own detailed assessments of detainees, including their medical and psychological conditions. Indeed, those assessments are considered a core function of BSCTs, and include psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees, including interrogation subjects.⁹⁴ Based on those assessments, members of the BSCT are supposed to advise interrogators, among other detention personnel.⁹⁵

The only general limitation on the use of detainee medical information is that it may not be used “in a manner that would result in inhumane treatment, would be detrimental to the detainee, or would not be in accordance with applicable law.”⁹⁶ The only specific application of this principle of which the Task Force is aware is that BSCTs are not permitted to share information about detainee phobias with interrogators.⁹⁷

The tenuousness of the distinction between medical information in the clinical record and medical information obtained by BSCTs is recognized in the guidance itself, as it urges BSCTs to withhold information about these assessments from detainees: “It is not appropriate, given the functions of the psychologist in this role and the DoD, to inform the detainee that he is being assessed by a psychologist” (there is an exception for direct interview and psychometric testing, where the BSCT member discloses that the assessment is not for medical purposes).⁹⁸ The prohibition on disclosing the identity of the psychologist compounds the ethical violation, as withholding the fact that an evaluation is taking place is inconsistent with the ethical standard common to the professions of requiring disclosure and transparency. As detainees’ own accounts and the many interviews conducted with former detainees by human rights investigators and journalists show, however, detainees have not been fooled, adding to their distrust of health personnel.

This problem will not be solved until current high-level policy is changed to prohibit the use of all medical and psychological information to pursue intelligence information.

Finally, the new guidance further expands the uses of detainee medical information for additional security purposes, including prevention of harm to any person, maintaining public health and order within a detention facility, and any other lawful law enforcement, intelligence, or security-related activity.⁹⁹

The inadequacy of policies on assessing and reporting detainee abuse

Despite its responsibility to ensure that all soldiers report abuse of detainees,¹⁰⁰ enemy prisoners, civilians, and other soldiers, from the time detainees first came into U.S. custody in 2001 through the public revelation of the Abu Ghraib scandal in April 2004, the DoD had established no field- or theater-level requirements for medical or psychological personnel to report abuse against detainees.¹⁰¹ When procedures for abuse reporting by medical and psychological personnel were finally established, they failed to meet international standards for reporting, as well as requirements set out by the Army Surgeon General in his review of medical practice regarding detainees.

INTERNATIONAL STANDARDS FOR REPORTING ABUSE: THE ISTANBUL PROTOCOL

The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, commonly known as the Istanbul Protocol, sets out international legal standards on protection against torture and guidelines on how effective medical investigations into allegations of torture should be conducted. Though not sponsored by the United Nations, the Istanbul Protocol was accepted as a UN document in 1999,¹⁰² and its principles have been recognized by a number of human rights bodies, including the UN General Assembly, the UN Commission on Human Rights, the UN Committee Against Torture, the UN Special Rapporteur on Torture, and the African Commission on Human and Peoples’ Rights. The protocol is often used by medical experts in U.S. court cases in which torture is alleged.

The Istanbul Protocol includes the following provisions for medical evaluations and reports:

- Evaluations must conform to standards outlined in the Istanbul Protocol
- Evaluations must be under the control of medical experts, not security personnel
- Medical evaluations and written reports must be prompt and accurate
- Written reports should include:
 - a Identification of alleged victim and conditions of evaluation
 - a Detailed account of allegations including torture methods and physical and psychological symptoms

- Record of physical and psychological findings
- Interpretation of findings and recommendations
- Identification and signature of the medical expert(s)

Annex 4 of the Istanbul Protocol, which sets out these components, is appended to this report.

The quality and accuracy of official medical evaluations of torture and cruel, inhuman, or degrading treatment can be ensured through an effective monitoring mechanism that oversees the entire investigative process of alleged torture and cruel, inhuman, or degrading treatment, reviews individual reports, adopts remedial measures, and offers training.

Neither the Istanbul principles nor any similar standards have been adopted, recognized, or even cited by the DoD.

DEFICIENCIES IN ABUSE-REPORTING

DIRECTIVES AND THE INADEQUACY OF REFORMS

Inadequate reporting of abuse was a product of the abdication of responsibility by DoD to provide adequate directives and instructions for medical and psychological personnel.

The origins of the problem likely are related to the fact that immediately after 9/11, abusive interrogation and confinement practices were authorized by the military; many of the practices that constituted torture or cruel, inhuman, or degrading treatment under international and domestic law were deemed to not be abuse. Military personnel at all levels were told that the interrogation and confinement practices used were lawful, and indeed were reviewed and approved by military lawyers.

Disciplinary investigations conducted within the military confirm that neither harsh forms of interrogation nor conditions of confinement were considered abuse. When logs of the interrogation of Mohammed al-Qahtani (described in chapter 1) were publicly disclosed, an investigation was conducted under the direction of General Randall Schmitt. The investigators acknowledged the use of long periods of sleep deprivation, constant interrogation, and the use of a leash to lead al-Qahtani around and perform dog tricks. They also noted that al-Qahtani was forced to wear a bra, told that he was a homosexual and that other detainees knew it, compelled to dance with a male interrogator, and required to stand naked with females present. General Schmitt's final report noted that the interrogation was harsh, but concluded that "every technique employed against the subject...was legally permissible under the existing

guidance." Even though General Schmitt found the "cumulative effect" to be "degrading and abusive treatment," he claimed al-Qahtani's "treatment did not rise to the level of *prohibited* inhumane treatment"¹⁰³ (emphasis added).

The decision by the DoD to exclude conditions of confinement and interrogation practices from its definition of abuse explains the Surgeon General's otherwise incomprehensible survey finding that, "By any measure, medical personnel were exceptionally vigilant in reporting actual or suspected detainee abuse."¹⁰⁴

The same Surgeon General's survey showed that most medical personnel were not trained in abuse reporting and that the definition of abuse and theater-level policies on abuse reporting expected of medical personnel simply did not exist until at least 2004 or 2005, as described in chapter 1. The survey noted that existing policies on training and reporting did not state when training should occur, who was responsible for training, or even how to define who was a health care provider.¹⁰⁵

To address these gaps, the survey made three key recommendations on reporting abuse. First, it recommended standardized policies for documenting and reporting actual or suspected detainee abuse at all levels of command (DoD, U.S. Army, Combatant Command, theater, and individual subordinate units) and continued command emphasis on reporting. Second, it sought standardized guidance for medical personnel on indicators of abuse and concise instructions on how and to whom medical personnel should document and report actual or suspected abuse. Third, it called for high-level guidance on the procedures for processing allegations of abuse not supported by medical evidence. One of its specific recommendations in the last category was to employ "A Health Professional's Guide to Medical and Psychological Evaluation of Torture," which is based on the Istanbul Protocol.¹⁰⁶

In the wake of the Surgeon General's survey and other internal investigations, reporting standards and procedures for medical personnel were established by the DoD for Guantánamo, but they remain seriously deficient. Abuse reporting requirements for health professionals fall far below the detailed standards the Istanbul Protocol requires and do not encompass many acts that violate the Geneva Conventions. Many of the instructions do not define abuse at all. Indeed, they continue the deficiency that acts against a detainee are not subject to reporting if they are authorized by policy.

The first reporting policy applicable to Guantánamo, established by Southern Command in August 2004, states in its entirety, "Medical personnel who gain knowledge of physical or mental cruel, inhuman, or degrading treatment of detainees will report this cruel, inhuman, or degrading treatment to the appropriate military authority."¹⁰⁷ In February 2005, the detention hospital at

Guantánamo issued a standard operating procedure applicable to medical personnel.¹⁰⁸ It provided that after an allegation of abuse, a hospital corpsman or a nurse, not a physician, does an initial history and examination. No standards for such an examination are stated except that the corpsman or nurse is expected to state the location and time of the incident, the mechanism of injury, and a description of physical findings. At that point, an on-call provider, who could be a physician, nurse practitioner, psychologist, or physicians' assistant, is required to examine the detainee within four hours, again with no standards set out for such an examination. The result is to be sent up the chain of command within the hospital and the hospital will report to higher authorities.

The question of abuse reporting reached the highest level of medical authority for the military, Assistant Secretary of Defense for Health Affairs Dr. William Winkenwerder. In mid-2005 he issued a policy that required health care personnel to report "a violation of standards" or "inhumane treatment" up the chain of command, but inhumane treatment was not defined, nor were any procedures for examinations specified.¹⁰⁹ Its reference to "violations of standards" implied that adherence to operating procedures regarding detention and interrogation would be exempt from reporting. Because the policy only applied to medical personnel providing treatment, behavioral science consultants were excluded.

Dr. Winkenwerder revisited the question of abuse reporting a year later in a formal instruction regarding medical care for detainees. The instruction adheres to the 2005 approach to abuse reporting regarding acts that are "violations of applicable standards."¹¹⁰ As in prior directives, the instruction does not say what steps a health professional should take to inquire into suspected abuse, nor what the threshold for reporting is, nor does it identify any obligation to connect clinical findings to abuse. The directive states that health providers must "have skills and knowledge to address the specific issues that arise in detention, including the ability to recognize possible abuse of detainees and take appropriate steps to report it,"¹¹¹ but it does not say what the skills or issues are. Finally, it states that training "on applicable policies and procedures" must be provided, but only "basic training" is required for all military medical personnel and "additional" unspecified training for medical personnel involved with detainees.

The U.S. Army Medical Department responded to the Surgeon General's report by including requirements for reporting abuse as part of a lengthy set of guidelines on medical support for detainee operations.¹¹² The guidelines are deficient both substantively and procedurally. Substantively, the definition of abuse includes physical acts that intentionally cause pain, injury, or suffering, as well as emotional abuse (threatening or humiliating a detainee, for example) and sexual abuse.¹¹³ While the definition encompasses some of the egregious

acts inflicted on detainees and eliminates the vagueness of the earlier definition, the document's omissions are just as significant. Conditions of confinement and interrogation practices that were central to the experience of thousands of detainees in U.S. custody, such as routine subjection to stress positions, isolation, bombardment with loud noise, sleep deprivation, and sensory deprivation, are not mentioned. Although these practices do cause injury and/or suffering, they were elsewhere consistently deemed by the military and CIA, as well as the Justice Department, not to constitute either torture or cruel, inhuman, or degrading treatment. By omission, the new guidelines leave those interpretations in place.

Procedurally, according to the guidelines, a treating physician has no obligation to investigate abuse he or she encounters in clinical examination of detainees. The guidance states:

While all medical staff members are responsible for immediately identifying and reporting potential and actual cases of abuse or assault to [the Criminal Investigation Division] and to the applicable [medical treatment facility] commander and higher headquarters, no further investigation is warranted beyond that necessary to render appropriate treatment, except in the case of rape or sexual assault, where medical personnel will collect and process rape kits, as set forth below. It is the role of [the Criminal Investigation Division] and/or the [military police] to investigate the allegation and collect evidence such as photographs.¹¹⁴

While referral for criminal investigation may be appropriate, the procedures omit the critical role of physicians and other clinicians in examining detainees to identify abuse. Further, once a referral is made, a medical examination of the detainee by a third party health professional (not necessarily a physician)¹¹⁵ is performed. Unlike the elaborate standards of the Istanbul Protocol, the examination requirements are set out in a single sentence: to document medical injury, trauma, and findings and review the detainee's overall health (in the case of alleged sexual abuse, there may be additional tests for pregnancy or sexually transmitted disease). The guidelines also do not impose an obligation to seek the origin or cause of the physical findings, an omission that has often characterized medical examinations that report no clinical evidence of abuse in cases in which torture or cruel, inhuman, or degrading treatment has occurred.¹¹⁶ Indeed, the standards discourage a medical examiner from making any inferences at all about abuse having taken place. The guidance states, "The medical report of the medical examination will read 'alleged' or 'suspected' abuse and the detainee will be identified as the victim where indicated."¹¹⁷ Finally, the

guidance provides no oversight or quality assurance structure to ensure accuracy of reporting and indicate the command's commitment to thorough investigations of reported abuse.

In 2008, the DoD established procedures for reporting "reportable incidents," defined as, "Any suspected or alleged violation of DoD policy, procedures, or applicable law relating to intelligence interrogations, detainee debriefings, or tactical questioning for which there is credible information."¹¹⁸ It also affirmed the 2006 reporting approach established by the Assistant Secretary of Defense for Health Affairs in 2005 and 2006.¹¹⁹ As a result, interrogation methods and conditions of confinement that are authorized in policy remain excluded from detainee abuse.

Behavioral science consultants, like other soldiers, have a duty to report abuse.¹²⁰ Although DoD guidance revised in 2012 for behavioral science consultants requires them to comply with this general duty to report abuse, it does not include abuse reporting among 14 subjects to be covered in the course of 168 hours of training.¹²¹ The most recent guidance notes that, like others, BSCTs can avail themselves of other mechanisms such as the Inspector General, criminal investigation organizations, and judge advocates.

The Task Force concludes that the abuse reporting system for medical and psychological personnel is in need of reform, in particular to incorporate the standards and methods of the Istanbul Protocol.

The inadequacy of internal guidance and accountability mechanisms

In the wake of revelations in 2004 about the treatment of detainees in Abu Ghraib prison, the U.S. military instituted several reforms germane to medical personnel. These include detailed guidelines for medical care of detainees, including a statement of the standard of care for detainees, establishment of a system for maintenance of detainee medical records, limitations on the use of medical personnel to carry out routine body cavity searches on detainees, and a prohibition on exploiting detainee phobias in interrogation. In 2012, the Assistant Secretary of Defense for Health Affairs established an ethics oversight board for detention medical practices that includes one non-DoD-affiliated representative.

These are important steps to provide both guidance and clinical review of practices. But the Task Force concludes that reform has been insufficient to protect the human rights of detainees and ensure professionally acceptable conduct by medical and psychological personnel going forward.

A key mechanism needed to ensure health professionals' adherence to professional practice standards is the quality assurance and credentialing process. The Task Force has no information that these mechanisms have been employed in the context of health professional actions toward detainees with respect to abuse reporting, adherence to ethical standards regarding hunger strikers, and other areas where DoD protocols and policies conflict with professional ethical standards and principles.

Within the military, credentialing of every licensed health professional occurs at the time of initial appointment and at every reappointment, which occurs at least every two years (or whenever privileges are granted or changed).¹²² This process gives each military service a regular opportunity to review provider performance. Moreover, unlike in civilian life, a health professional in the military must be credentialed through a medical facility, regardless of whether he or she practices in that facility. Though each military service has a different mechanism for credentialing its providers, the requirements are uniform and set by the DoD.

By law, health professionals within the military must also be licensed by a state.¹²³ In the military, the commanding officer of a facility offering credentials is responsible for ensuring that anyone who provides health care in his or her jurisdiction, regardless of physical location, is licensed.¹²⁴ As part of this process, the commander must query the National Practitioner Data Bank, which provides information on adverse actions taken against a licensed professional by a state or credentialing entity.¹²⁵ The credentialing requirements are linked to the DoD's Centralized Credentials and Quality Assurance System,¹²⁶ which includes regular, systematic, and comprehensive reviews of the quality of health care.¹²⁷ As part of quality assurance, military treatment facilities are also required to identify events affecting patient care and outcomes that occur in their facilities, conduct an analysis of their root causes, and form a corrective action plan for each event.¹²⁸

Disciplinary actions taken by the military against a practitioner, including those affecting their privileges to practice, must be reported to the Federation of State Medical Boards, the National Practitioner Data Bank, and the DoD's quality assurance system.¹²⁹ The reporting system is thus supposed to ensure reciprocal knowledge and reporting between states and the military, so that unethical or unprofessional conduct in one sphere is brought to the attention of the other.

In the DoD, any unprofessional or unethical conduct is grounds for taking action to remove or reduce credentials to practice or to take other administrative steps.¹³⁰ The military services articulate the prohibition on unprofessional and unethical conduct in various ways, but properly applied, all of them cover

the detainee abuse described in this report. For example, the U.S. Air Force, Navy, and Army focus on competence (medical knowledge, expertise, or judgment), conduct (unprofessional, unethical, or criminal), and impairment (medical conditions, mental health conditions, or alcohol/drug abuse/dependence) that may reduce or prevent the provider's ability to safely execute his or her responsibilities in providing health care.¹³¹

There are multiple routes for reviewing the conduct of licensed health professionals. The military services stress that all health care providers should participate in monitoring and evaluation of issues in patient care. As such, peer evaluations, as well as recommendations obtained from credentials committees, may also be relied on in reviews of clinical privileges.¹³² Moreover, the privileging authority of each branch of service is expected to conduct a thorough evaluation annually of the current competency of all non-privileged health care providers assigned to operating forces. These include staff members who do not have clinical privileges but who are required to have a license, certification, or registration. Depending on the service, these individuals may include medical technicians, corpsmen, pharmacists, clinical nurses (registered nurses, licensed vocational nurses), emergency medical technicians, dental hygienists, and others.

Military policies that conflated legal and ethical standards, combined with bad-faith interpretation of those legal obligations, may have undermined the effectiveness of the otherwise robust disciplinary processes for countering detainee abuse, since adherence to the military's rules and policies would have likely sufficed to find that the health professional met all standards of practice. Once appropriate standards of conduct are in place, and if invoked appropriately and linked to quality assurance reviews, the military's oversight procedures could promote ethical conduct toward detainees, discipline offenders, and become a venue for challenging health professional involvement in the abuse of detainees.

Hunger strikes and force-feeding

AT GUANTÁNAMO BAY, hunger strikes became the only form of protest available to detainees against indefinite detention and the abusive conditions in which they were held. Hunger strikes have continued even as conditions of confinement have improved in the past few years; the dismal outlook for potential release—even for those who have been found not associated with terrorist acts or organizations—remains as bleak as ever. Some of the hunger strikes have been joint actions, with dozens and in some cases over 100 detainees participating. Hunger strikes have also taken place at other U.S. detention facilities overseas.

During some periods in 2002 and again in mid-2005, authorities at Guantánamo initially responded to hunger strikes by seeking to engage with detainees and resolve grievances, but in each instance they eventually sought to defeat the hunger strike through the use of force-feeding. Then in late 2005, the Department of Defense (DoD) introduced five-point (and sometimes six-point) restraints for force-feeding, including the use of a restraint chair, which is still in use today, that binds a detainee's arms, legs, and body for up to two hours at a time while feeding takes place through a nasogastric tube. Some detainees have undergone this procedure multiple times a day for months at a time. The Task Force is aware of no precedent for using physical restraints to force-feed hunger strikers for more than a handful of episodes, much less for weeks and months (and in at least one case, years) at a time.

The DoD's current policy, established in 2006 despite criticism from medical organizations and others for its use of force-feeding, is to characterize hunger strikes as acts of self-harm rather than as protests and to justify force-feeding as a life-saving intervention.¹ As will be discussed in this chapter, however, the available evidence suggests that its policies and practices are directed toward ending protests by forcible breaking of hunger strikes. After reviewing the available record—which is incomplete but nevertheless illuminating—we on the Task Force conclude that the DoD's practices, including

the use of restraint chairs, depending on the exact circumstances in each case, amounted to either torture or inhuman and degrading treatment against detainees engaged in protests.

From the first hunger strikes at Guantánamo Bay, physicians, along with nurses and other medical personnel, have played a central role in responding to hunger strikes because of the medical implications of fasting and the medical oversight of force-feeding. At Guantánamo, the record available to us shows that doctors responding to hunger strikes, acting under the direction of the military detention center command and protocols, have not acted with professional independence, have not adhered to national and international ethical standards on management of hunger strikers, and have not followed sound medical practice in responding to the needs of individuals under their care. Instead, they have become agents of a coercive and counter-therapeutic procedure that for some detainees continued for months and years, resulting in untold pain, suffering, and tragedy for the detainees for whom they were medically responsible.

This chapter begins with a brief review of the history of hunger strikes, a description of the clinical consequences of food deprivation and their implications for medical management of hunger strikers, and the ethical requirements, established by the World Medical Association and U.S. medical organizations, for the role of a physician in responding to hunger strikes among people in custody. It then examines hunger strike practices by the U.S. military at Guantánamo and elsewhere, including their evolution over time. The chapter concludes with recommendations for DoD policy changes that would both allow the DoD to adhere to its obligations under Common Article 3 of the Geneva Conventions and the Convention Against Torture and permit physicians to respond to a hunger striker in a manner consistent with the ethical standards and sound medical practices to which they are bound.

History, definitions, and clinical course

A hunger strike by a prisoner generally refers to the use of prolonged refusal to eat as a form of protest. It is typically designed to gain public attention and put pressure on authorities to accede to strikers' demands. A hunger strike represents a prisoner's effort to retain, or regain, some control over one of the few elements of power left to the prisoner while incarcerated. Hunger strikes are usually most effective where there is some respect for basic human rights or where there are political and diplomatic reasons to convey such respect.² They can indeed be an effective tactic, generating media attention to conditions of

confinement or lack of due process, gaining sympathy from the public, or putting pressure on authorities to reform.

The very possibility of public engagement, though, is often seen by prison authorities as intolerable, even a form of blackmail, which they seek to avoid by ending the hunger strike as quickly as possible. As prolonged fasting can ultimately become a medical problem, judicial or custodial authorities sometimes call upon physicians not to perform in their appropriate professional roles in responding to the medical needs of hunger striking prisoners, but to participate in administrative or disciplinary measures involving intervention through the use of harsh measures such as force-feeding. This leads to conflicts between prison custodians and the requirements of medical ethics.

There is a vast body of literature on hunger strikes.³ Perhaps the earliest recorded hunger strike against a custodial authority was that of Vera Figner, a revolutionary in Czarist Russia in 1889.⁴ At the beginning of the 20th century, countless British and U.S. suffragettes on hunger strikes suffered ignoble force-feedings, widely commented upon and criticized at the time, at the hands of authorities. Posters showed how these brave women were subjected to force-feeding through a tube inserted by a doctor into their stomach, while they were held down, struggling, by medical staff. Mahatma Gandhi, protesting against the British government during the first half of the 20th century, is the figure most often associated with the contemporary idea of hunger strikes.

In the past thirty years, hunger strikes have occurred on many continents. The most well known are the cases of Bobby Sands and fellow Irish Republic Army members in 1981 during the "troubles" in Northern Ireland. That strike came at a time of escalating protests, violence, mass arrests of I.R.A. militants, accusations of brutality, and a political confrontation with British Prime Minister Margaret Thatcher. In the midst of the strike, Bobby Sands was elected to Parliament. He and nine other hunger strikers died of starvation in the protest.⁵ After their dramatic deaths in Maze Prison, many hunger strikes took place during the next 15 years in the Middle East, Latin America, South Africa, and elsewhere, but none of them led to showdowns and loss of life as occurred in Northern Ireland.

In the 1990s and early 2000s, hunger strikes in Turkey, which were accompanied by violent assaults by authorities within the prison and solidarity hunger strikes by families, led to an unprecedented number of deaths—including those of non-incarcerated family members who joined the fasts. At least 100 people died, most from prolonged, not acute, malnutrition.⁶ In the Turkish strikes, not all of the hunger strikers were volunteers and it remains to be fully disclosed exactly how many prisoners may have been "designated" by prisoner leaders as

volunteers for the “death fasts.” What is known is that Turkish authorities demanded that physicians force-feed the hunger strikers, but the Turkish Medical Association took the position that it was unethical to do so if a competent prisoner refused to eat, and so its members declined to participate.

Despite the long history of hunger strikes, there is often confusion concerning what constitutes a hunger strike, as the term is used to cover a variety of situations in which a prisoner refuses food as a form of protest. Two main types of people (and accompanying acts) can be distinguished: “food refusers” and true “hunger strikers.” Food refusers are prisoners who, for any motive, declare themselves to be on a hunger strike and may refuse to eat for a day or a few days. Food refusers, however, have no intention of maintaining the fast or willingness to hurt themselves by their fasting. Indeed, food refusal is quite common among prisoners, who may voice complaints but never intend to go on a prolonged fast. Medical staff who observe this category of prisoners sometimes call them “professional” hunger strikers or people who engage in “nuisance fasting,” as it generates extra work for the medical staff and the refusal is soon abandoned. By contrast, a hunger striker, as we use the term here, is a prisoner who uses fasting as a way of protesting, and is willing to place his health—and perhaps his life—at risk so as to be heard by an authority. Often a hunger strike is a response to the lack of any other meaningful way for his grievances to be heard and resolved.

The historical record shows that despite the willingness of a hunger striker to suffer from the results of his acts, it should be understood that a hunger strike is designed to achieve a purpose, usually an administrative, legal, or political change, not to inflict self-harm. In other words, the striker’s goal is to live better in the world, not to die in it. Bobby Sands was as determined as any hunger striker could be, but had he obtained concessions from the British government any time before his death, he would have taken nourishment. A useful analogy may be to Greenpeace activists who sailed their boats into the Pacific atoll where French nuclear tests were being carried out. They were not seeking to get themselves blown up—they were most certainly not suicidal—but they were willing to risk their lives, as a last resort, to publicize their protest against nuclear weaponry. Authorities, judges, families, and lawyers, however, often mischaracterize hunger strikers’ acts as suicidal or demonstrating intent to self-harm.

Understanding of what acts constitute a hunger strike has evolved. Before the Turkish protests at the end of the 20th century, hunger strikers were often classified as “serious” when, like Bobby Sands, they were effectively ingesting only water, and thus putting their lives in jeopardy. The Irish hunger strikers fasted in this way and died after eight to ten weeks from acute malnutrition.

Any other form of prisoner fasting was deemed to fall short of a “serious” hunger strike. Prisoners who fasted but also took some nourishment or vitamins on the side were often deemed by authorities to be “cheating” on their strike, and were hence catalogued as not serious about conducting a hunger strike. This distinction was eroded when Turkish hunger strikers consumed some nutrients, not to “cheat,” but to prolong the fast. They succeeded in prolonging their lives far longer than Irish hunger strikers did. Thus, it is not possible to judge the seriousness of a hunger strike on any one criterion alone. Each context, and each person, must be judged individually.

There are many varieties of fasting and different concepts of what constitutes eating, but for the purposes of this report in situating the kinds of hunger strikes that have occurred at Guantánamo, only three types of hunger strikes⁷ are important.

- The dry hunger striker takes no food or water of any kind. This is often seen by both the hunger striker and the authority as a very dangerous form of hunger strike, as without water a body cannot survive more than a matter of days at most, depending on climate and temperature. For a hunger striker, this approach is counterproductive, as the hunger strike needs time to exert any effect. In reality, such dry hunger strikes never last longer than a few days, as the suffering from lack of water intake is objectively intolerable. Custodial and political authorities, and the media, are often overly “impressed” by dry strikes, although there is no known record of a hunger striker dying on a dry strike.
- Total fasting, as we use the term here, means no solid food of any kind, and only ingestion of water. Two liters of drinking water a day, with or without salt, preferably mineral water, will provide the amount needed to survive. In a still “rigorous” hunger strike, other nutrients are added to the water.⁸
- Non-total fasting refers to a less rigorous hunger strike, and includes practically any other type of fasting, for example, with vitamin and mineral intake, or sometimes with liquid nutrients or other supplements taken in addition to plain water.

The medical implications and thus the seriousness of a hunger strike depend on its duration and the physical condition of the hunger striker, not just on what is ingested. A non-total hunger striker may be just as determined as a total one and can lead to death as well, only at a much later stage, as was the case in Turkey.

The medical consequences of a hunger strike are often misunderstood. A healthy, normally nourished adult, without any medical contraindication to prolonged fasting, should experience no medical consequences when fasting totally (taking only water) for about 72 hours. After 72 hours, the onset of ketosis, the presence of metabolites known as “ketone bodies,” usually occurs.⁹ Ketosis is often discernible clinically on the breath by what has been described as a pear-like smell. Ketosis subdues the voracious sensation of hunger, or “hunger pangs,” experienced during the first two to three days of total fasting. It has been argued that, as a simple rule of thumb, total fasting for longer than 72 hours qualifies on metabolic grounds as a hunger strike.¹⁰ The purpose of this rule of thumb is to eliminate any confusion with short-lived fasting.

At the other end of the spectrum, another rule of thumb governs when total deprivation of food (ingesting only water) becomes fatal. During the 1981 hunger strikes in Northern Ireland, medical reports showed that death occurred sometime between 55 and 73 days.¹¹ Similar cases have confirmed this range, which takes into account differences in initial physical constitution and individual adaptation. In between these extremes, experience suggests that the fifth or sixth week, the “ocular motility”¹² phase (when deficiency of the vitamin thiamine results in tell-tale abnormal movement of the eyes), is particularly difficult for the hunger striker. By the sixth or seventh week, hunger strikers enter the final stages of fasting, during which they may no longer be capable of clear discernment. Survival for more than 10 weeks of total fasting is practically impossible.

In short, a “72-72” maxim is helpful: a minimum of 72 hours for any fasting to be taken seriously as a hunger strike and a maximum of 72 days for the length of time a hunger striker practicing a total fast can hope to survive. This knowledge is indispensable for physicians in counselling and determining appropriate medical care. For example, the hunger striker may agree to add thiamine and glucose to water intake, which can prolong the protest.

Finally, clarity is also necessary on the meaning of force-feeding. We use the term to mean that feeding, usually through a nasogastric tube (as described below), is involuntary, undertaken against the wishes of the person subjected to it. Force-feeding may be, but is not usually, accompanied by the use of physical restraints. Force-feeding implies some form of coercion, which can take many forms. Prisoners who have to accept nasogastric feeding because they know or fear they will be punished or have the tube forced into them cannot be said to “accept” being fed. By contrast, nutrition may be supplied to a hunger striker through means other than eating, such as through tube-feeding, with the tacit

or express agreement of the prisoner. In such a case it is “artificial feeding.” Force-feeding is always artificial; artificial feeding may be freely accepted by the prisoner and is then acceptable.

Ethical framework and clinical response

The role of the physician in treating prisoners on hunger strikes is fraught with difficulty. As noted above, prison officials often view the physician as the instrument by which they can control the prisoner by literally forcing a prisoner to end a strike. The physician’s own sense of responsibility for the well-being of the patient can also make it difficult to defer to a competent prisoner’s decision to fast, as ethical standards demand. At the same time, the physician must ensure that the prisoner’s decision is voluntarily or freely made, not entered into because of pressures from other prisoners or because of a mental condition. The physician must also counsel the patient, not just about the medical consequences of not eating, but about available options. The interaction between physician and prisoner is complex and requires ongoing, individualized clinical judgments according to ethical standards.

THE WORLD MEDICAL ASSOCIATION’S DECLARATION OF MALTA

To help them navigate the complex requirements while upholding ethical standards, the World Medical Association has provided both an ethically principled framework for and guidance to physicians caring for prisoners on hunger strikes. Its first guidance came in the Declaration of Tokyo in 1975, which concerns medical involvement in torture, and stated that:

Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.¹³

The provision was not an attempt to address hunger strikes generally, but rather the physician’s responsibilities where a prisoner being tortured protested against his treatment by going on a hunger strike.¹⁴ The declaration provides that a physician should not be obliged to administer nourishment against the prison-

er's will and thereby effectively revive him for more torture. The use of the word "artificially" instead of "forcibly" to refer to the use of force in feeding a hunger striker via nasogastric tubing was imprecise and did not take into account the difference between the two terms explained above. "Artificially" in the Tokyo Declaration meant, but did not clearly convey, that feeding against the prisoner's will was proscribed. Nevertheless, the 1975 declaration was correctly interpreted by many groups, including the American Medical Association, to prohibit force-feeding, even though the term itself was not used.¹⁵

A hunger strike in South Africa during the 1980s led doctors there to seek further guidance from the World Medical Association. As a result, the association drew up the Declaration of Malta in 1991, which defined the different forms of fasting, the role of doctors, and the effects of "terminal" hunger strikes. The Declaration of Malta affirmed the principle of informed consent, required doctors not to be involved in efforts to coerce the prisoner to end the strike, and urged full communication with the hunger striker about its consequences and dangers. The declaration did not explicitly discuss force-feeding, advising only that in the case of a prisoner who became confused or lapsed into a coma, the physician should use his or her judgment whether to feed or provide further treatment, taking into account the prisoner's prior decisions and expressed wishes.

The force-feeding question was not addressed because, at the time, the use of coercion to force-feed prisoners was rare. During the Northern Ireland hunger strikes in 1980 and 1981, the question of force-feeding did not even arise. British doctors did not envisage the possibility "that there [would] be any circumstances where the due process of law would require a physician to force-feed anybody against their will."¹⁶ Thus a clear position for the upholding of patient autonomy was taken in these Northern Ireland hunger strikes. Force-feeding was also discredited after a mistake in the Middle East in the early 1980s that resulted in the death of two prisoners who were fed forcibly, as liquid nutrients were introduced into the trachea rather than the esophagus. After that incident, force-feeding, already rarely invoked, practically disappeared as a response to hunger strikes.

Later experience with hunger strikes, especially the confrontation between the national medical association and government in Turkey, and then the explicit policy of force-feeding prisoners at Guantánamo, led the World Medical Association to comprehensively revise the Declaration of Malta in 2006.¹⁷ Its revised policy was accompanied by a glossary and background paper.¹⁸ Malta 2006 explicitly addresses how the principle of patient autonomy (informed consent and the right to refuse treatment) harmonizes with the

principle of beneficence, and concludes that when a conflict exists, the autonomy of the informed, competent patient prevails as the governing principle. This is because the obligation of beneficence "includes respecting individuals' wishes as well as promoting their welfare," and does not necessarily involve "prolonging life at all costs, irrespective of other values."¹⁹ The obligation of avoiding harm "means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting."²⁰ Thus, competent individuals who are informed and able to understand the implications of their choice should not be treated against their will. They can refuse food and state their wish to refuse food in the event they lose mental capacity to make decisions.²¹

The World Medical Association declared that force-feeding a competent hunger striker is never permitted, as it violates the principles set out above as well as the principle of informed consent. It stated:

*Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.*²²

The use of the phrase "inhuman and degrading treatment" conveyed that in the World Medical Association's judgment, force-feeding accomplished by force, threat, or coercion, including the use of physical restraints, is not only an ethical breach but, in cases of armed conflict, a violation of Common Article 3 of the Geneva Conventions of 1949 and the Convention Against Torture. Furthermore, the World Medical Association made clear that, "It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will."²³

THE IMPORTANCE OF DOCTOR-PATIENT RELATIONSHIPS BASED ON TRUST

The Declaration of Malta accompanies its ethical principles with clinical guidelines that, along with other sources, provide valuable instruction on how the physician should respond to a hunger strike.²⁴ The physician's role is not just about evaluating the detainee's medical and psychological condition, warning the detainee about the consequences of fasting, and monitoring the detainee's caloric intake, blood pressure, weight-loss, and other medical consequences of fasting. The physician's role is even more fundamentally one of advising, counseling, listening, and assisting the prisoner in clarifying goals, desires, and deci-

sions. To perform this role, there must be a true doctor-patient relationship based on trust. As Malta 2006 declares:

Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimizes harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.²⁵

Establishing trust requires continuity of care between the physician and detainee. The physician must convey to the patient the fact that he or she is there to attend to medical needs, to answer questions, and to inform the hunger striker about any medical facts that are relevant to the particular case. Trust is difficult in any prison environment,²⁶ so special effort must often be made to provide the basis for and to establish it.

Creating and maintaining trust precludes any role of the physician as an agent of or acting on behalf of the authorities to convince the hunger striker to stop the strike or to threaten the striker with adverse consequences of a refusal. Any imposition by authorities of a “medicalized” solution to a hunger strike by asking a physician to seek to induce a prisoner’s compliance with authorities’ requirements or tell the hunger striker to either end the hunger strike or be force-feed, undermines trust, perhaps irretrievably. The bond of empathy between the doctor as healer and his or her patient is also destroyed when physicians act in security or intelligence roles, such as through participation in coercive interrogations.²⁷

Such roles not only potentially implicate physicians in cruel, inhuman, or degrading treatment or torture but prevent them from acting as intermediaries, or possible catalysts, towards compromise, helping to reach a calm solution to the conflict. In cases of extreme distrust, like that at Guantánamo as described in chapter 1, playing a counselling role may be problematic for staff physicians. Even if physicians have not participated, even passively, in torture or cruel, inhuman, or degrading treatment, they are likely seen by detainees as being part of a coercive system, thus making the possibility of establishing a relationship of trust impossible. In such cases, independent physicians can be brought in by authorities to fill this essential clinical role.

Thus, from the start, physicians should convey to the prisoner that they are not there as prison officials to try to convince hunger strikers to stop their protest. Physicians are there to see to prisoners’ health, to answer any questions

they may have, to explain how fasting and metabolism work, and above all to listen to and maintain a constant line of communication with prisoners. A physician has to convey genuine concern for health and for providing professional care. This stance in most cases should counterbalance any qualms or legitimate fears a hunger striker may have about a doctor’s role. One aspect of this role is to ensure that the prisoner’s dignity is not compromised and to intervene with authorities to ensure that the hunger striker is not placed in a bleak or demeaning environment as a means of punishment.

Physicians also must ensure their own clinical independence.²⁸ This means that they may neither “allow third parties to influence their clinical medical judgment” nor “allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.”²⁹ Physicians have to establish, within the custodial hierarchy, that they must have a free hand in dealing with all matters relating to health as well as any medical interventions. They cannot take orders that preclude the exercise of or go against medical judgment, let alone medical ethics. Similarly, they must assure prisoners that confidentiality will be respected, and must have confidence that the authorities will cooperate, for example, by allowing consultations without guards present (or, if security procedures demand their presence, out of earshot).³⁰

The physician’s role in the hunger strike begins when assessing what the individual hunger striker’s intentions are and how resolute the striker seems to be about continuing.³¹ The voluntary nature of the hunger strike is key; whatever decision a hunger striker makes has to be the striker’s own, as bodily integrity, the right to refuse treatment, and ultimately life, are involved.

A hunger striker’s decisions must be made without coercion from any individual or group, such as fellow prisoners, family, or political or religious groups.³² Such pressure can be intense, and it is paramount that the doctor ascertains that the hunger striker can make all-important decisions freely. The physician should seek to answer some key questions: How resolute is the hunger striker? How determined is the striker to push his protest through? Can the striker accept a compromise solution that would allow the fasting to stop? What is behind the protest? Is there some misunderstanding that could be easily corrected so as to defuse the situation? Is there peer pressure from other prisoners? Or pressure from within the group of hunger strikers themselves when it is a collective action?

As part of this assessment, the physician needs to take a medical history and conduct an examination to determine the prisoner’s competency and whether his food refusal is voluntary.³³ If refusal of food is a manifestation of some mental disorder, such as depression, psychosis, or anorexia, then the situation is

not a hunger strike, and the physician should direct care at treating the underlying disorder or mental illness. For this reason, a comprehensive assessment of the physical and mental health of the fasting person is an essential feature of the evaluation for determining the proper management of a hunger strike. An accurate assessment of both the physical and mental health of a hunger striker requires a precise and candid history, which in turn requires the patient's collaboration.

It is also critical for the physician to distinguish between behaviors intended to kill oneself and behaviors undertaken to make a statement or protest that could risk death. Though most hunger strikers do not have a mental disorder, an examination of a hunger striker's psychiatric and medical history may reveal factors affecting decision-making abilities and cognitive processes.³⁴ On the other hand, the examination may show that the hunger striker is unimpaired and pursues a total fast with a positive, political goal that, in his eyes, will benefit himself or his community, even though he may need to die if his plea is not heard.³⁵ The Turkish prisoners who went on repeated and prolonged hunger strikes in the late 1990s did not want to die, even if they were provocatively vociferous in their action, declaring they were on "death fasts."³⁶

In performing these clinical assessments, physicians should not let their overall vision of the situation be obscured by an unwarranted concern that the hunger striker will soon die. As noted above, there are at least thirty full days before the "ocular" phase begins, time enough for the physician to play an appropriate role.

Physicians should also counsel prisoners on the clinical consequences of fasting, showing respect for the prisoners' autonomy and right to make their own decisions regarding eating and feeding. Hunger strikers should be given accurate clinical information about the foreseeable effects of fasting, such as that when they stop eating, underlying health problems are likely to come to the foreground. They should be asked to indicate whether they would accept treatment or pain relief for these underlying problems as well as what their wishes are regarding food and medication should they become mentally impaired as a result of the fast.³⁷ The physician can help the hunger striker prepare an advance directive to ensure that the prisoner's wishes are respected, and the physician can keep the directive confidential.³⁸ The physician should also counsel the prisoner about options such as increasing fluid intake, taking nutrients, and other steps to preserve his health during the fast.³⁹

Another and more difficult role for the doctor is to serve as medical intermediary if consistent with the patient's wishes. The purpose is not to negotiate the

terms of the hunger strike, nor to intercede on behalf of either party, but rather to determine the hunger striker's intent and what possible alternatives to prolonged total fasting might be acceptable. For example, the hunger striker may be willing to lower the bar of contention so that a compromise can be reached with the authorities by taking vitamins and perhaps other nutrients to allow time for negotiations. In this way the physician can act in the hunger striker's best personal health interests, while respecting his freely taken decisions. In some cases, the hunger striker may agree to receive artificial feeding, thus allowing him not to lose face (by quitting the hunger strike) while keeping him out of danger until a solution is found.

The intermediary role can be highly effective. In one case, an International Committee of the Red Cross (ICRC) physician played a key role in responding to a hunger strike in a Latin American country, persuading the hunger strikers to accept IV lines with vitamins without compromising their message during the strike. A representative of the Catholic Church ultimately brought about a peaceful resolution.

In a collective hunger strike, as frequently has taken place at Guantánamo, the situation is more complex, as a small number of "hard liners," or sometimes even just one leader, may be unyielding and make it difficult for any other hunger striker to deviate from the group's plan. A detainee may fear taunts or reproaches from other prisoners, the shaming of his family, or even loss of respect from guards, if he backs down. The physician is obligated to seek to protect or ameliorate the effects of such coercion.⁴⁰ The key is for the physician to speak to each hunger striker individually. If a relationship of trust has been attained, some members of the group may admit in confidence that they do not want to participate. One potential response is for the physician to help separate hunger strikers from each other. This does not mean isolating them or putting them in solitary confinement. Once the peer pressure is relieved, the road to reconciliation is open. The physician may also arrange for the hunger striker to be transferred to the sick bay, where (voluntary) "therapeutic feeding" may be undertaken.

As the fast proceeds, the physician should continue to monitor the hunger striker's physical and mental condition. Usually, when the hunger strike ends, the physician can manage the introduction of food to ensure protection of the individual's health. The physician, of course, must attend to the prisoner's medical needs, but also defer to the prisoner's wishes if he is competent and his decisions are not made under duress. The Declaration of Malta is clear that it can be preferable and ethical to allow a prisoner to die with dignity, if it is clearly the individual's stated wish to refuse any treatment, rather than requiring him to submit to repeated interventions against his will.⁴¹

The final role of the physician is effective communication with authorities. The physician can start by assuring authorities that they have at least four weeks to address the underlying causes of the hunger strike before serious health issues arise and persuading them that force-feeding is not necessary to keep the hunger striker alive. This step can also enable the physician to assure the hunger striker that no force-feeding is going to be used, which in turn reinforces trust in the physician—the opposite of what happens when physicians become involved in breaking hunger strikes.⁴² In playing this role, the physician can help avoid the escalation and confrontation that ensues when authorities take harsh and hasty action, leading the hunger striker to become potentially more intransigent than he ever intended.

All too often, however, authorities and even medical supervisors view the role of the doctor as exclusively to monitor medical signs and symptoms, to inform the hunger striker that fasting can ultimately result in harm to him, sometimes irreversible, and to advise him of the different possible interventions that can reduce the risks of irreversible harm. This narrow role ignores the roles the physician can play early in the process when better solutions exist, as it focuses exclusively on what consequences are late in the fast.⁴³

The International Council of Nurses, a federation of more than 130 national nursing associations globally, has addressed hunger strikes, albeit in abbreviated fashion, in policy statements on prisoners and detainees. In 1998, the council's brief policy statement on the nurse's role in treatment of prisoners and detainees did not address hunger strikes directly, but stated that, "Prisoners and detainees have a right to refuse treatment or diagnostic procedures and to die with dignity and in a peaceful manner."⁴⁴ In a 2011 statement, however, the council specifically addressed the nurses' role in hunger strikes, stating that, "Prisoners and detainees, including those on hunger strike, have a right to clear and sufficient information; to consent for or refusal of treatment or diagnostic procedures; and to a dignified and peaceful death."⁴⁵ While hardly as detailed as the World Medical Association standard, the nurses' position is unequivocal in its respect for the decisions of the prisoner and, by implication at least, opposes the participation of nurses in forced feeding.

Some prison authorities, in collaboration with health agencies, follow the approach described in this section. In the United Kingdom, for example, the Department of Health, in conjunction with the Ministry of Justice's National Offender Management Service and the Home Office's UK Border Agency, published guidelines for the clinical management of people refusing food in immigration detention centers and prisons that stressed the physician's independent and supportive role.⁴⁶

Hunger strikes at Guantánamo Bay and the evolution of U.S. policy

2002-2005

In late February 2002, weeks after the prison opened at Guantánamo Bay and with tensions running high between prisoners and guards after protests and a riot, a group of prisoners went on a hunger strike. Within two days almost 200 detainees had skipped a meal. The commanders and medical staff lacked rules, guidance, or a strategy for responding.⁴⁷ The medical leadership understood that hunger strikers could survive for many weeks, but the strike was nevertheless seen as a challenge to prison authority, interrogations (as prisoners would decline to speak during questioning), and public relations.⁴⁸ The facility's commander, Marine Major General Michael Lehnert, with help from the ICRC, decided to seek to address the prisoners' concerns personally by respectfully interacting with the hunger strikers while separating the strike's leaders from the others. Most detainees abandoned the fast quickly, and the number of strikers was reduced to the low teens. Soon thereafter, however, General Lehnert was relieved of command, and the response by the new commander to hunger strikes was more aggressive. By May 2002, two detainees are reported to have been force-fed.⁴⁹

Another coordinated hunger strike took place between October and December 2002. Although the Task Force has not been able to learn whether the DoD had policies on hunger strikes in place at that time, we do know that it had policies in place by 2003.⁵⁰ Under those policies, a detainee at Guantánamo who had missed nine consecutive meals (about 72 hours) or had not drunk fluids for 24 hours was to be segregated and evaluated daily by a medical officer. It is not clear from available documents whether psychological evaluations were conducted to determine whether any detainees suffered from a mental disorder that rendered them incapable of making "rational, reasonable" decisions concerning the hunger strike.⁵¹ One standard operating procedure called for "supplemental feeding" when the detainee's weight reached 85-90 percent of ideal body weight.⁵² A later medical standard operating procedure, issued in August 2005, declared that "every attempt will be made to allow detainees to remain autonomous up to the point where failure to eat or drink might threaten life or health."⁵³

According to an October 2005 declaration filed in a judicial proceeding by Captain John Edmondson, commander of the Joint Medical Group⁵⁴ at Guantánamo from July 2003 to January 2006, where a physician deemed intervention necessary, the physician was to make a recommendation for "involuntary

intravenous therapy” or enteral feeding, which consists of placing a tube through the individual’s nose to the stomach.⁵⁵ Captain Edmondson stated that lubricants were used to insert the tube and non-narcotic drugs were administered to ease discomfort or pain from insertion, although in rare instances they administered narcotic drugs for pain.⁵⁶ According to Captain Edmondson, no medical corpsman or physician’s assistant performed these roles.⁵⁷ This claim, however, is contested, as detainees have alleged that non-medical personnel such as guards were involved in inserting and removing feeding tubes. Captain Edmondson also described the counseling role of physicians as informing the detainees of the consequences of not eating and alternatives to involuntary feeding.⁵⁸

This form of medical intervention was called “involuntary feeding” by the authorities, since through October 2005, the detainees were said to accept the nasogastric tube without force or restraints, though it is not clear whether this acceptance represented acquiescence or mere failure to physically resist. Captain Edmondson’s declaration states that virtually all hunger strikers did not resist insertion of feeding tubes and only 10 detainees had been subjected to the use of four-point restraints to accomplish insertion. He also stated that flow of nutrients through the tube itself was voluntary and controlled by the detainee.⁵⁹ He further stated that detainees who remained in their cells came voluntarily to the door and handed the tube to a nurse, who connected the bag of nutrition to the tube. He stated that detainees could walk around their cells in the process.⁶⁰

The decision to feed detainees involuntarily, however, was restricted to the Joint Task Force commander of the detention facility, a non-medical person; others, including medical staff, were prohibited from commencing forced feeding without the commander’s approval.⁶¹ The administrative (and political), rather than medical, nature of the decision is indicated not only by the need for written approval of the commander but by the requirement that he notify the commander of the U.S. Southern Command, who in turn was required to inform appropriate Joint Staff and DoD offices,⁶² i.e., the highest levels of military and civilian command.

Captain Edmondson stated in his declaration that the process of force-feeding takes two hours.⁶³ Guards are instructed to weigh the detainee daily and report the quantities of food and water the detainee has taken. Once enteral feeding is initiated, the physician is permitted to order it to continue. According to the policy, if the detainee eats nine consecutive meals, enteral feeding is discontinued.

Through mid-2005, there were few reported instances of involuntary feeding at Guantánamo.⁶⁴ In June and July 2005, however, after a long period of tension between detainees and authorities, a hunger strike took place at

all five camps, reportedly involving 200 prisoners, over complaints of lack of due process in obtaining release, lack of respect for the Koran, and inhumane living conditions.⁶⁵ The commander of the Joint Detention Group, Colonel Mike Bumgarner, decided to negotiate with detainee leaders, resulting in an end to the hunger strike on July 28, 2005, based on his commitments to bring the detention center into compliance with the Geneva Conventions.⁶⁶ According to media investigations, Bumgarner made serious efforts to address the detainee’s complaints after negotiating with six detainee leaders. However, in August 2005, the negotiations fell apart. Major General Hood, the Joint Task Force commander, restricted communication among the detainee leaders and detainees were angered by violent treatment of a detainee by a quick-reaction force, a special group of guards who intervened forcibly in cases of alleged security breaches, and other incidents.⁶⁷ In two of the camps a riot broke out, in which detainees severely damaged their cells. The detainee negotiator accused the authorities of betrayal and a new hunger strike began. According to their lawyers, between 131 and 210 detainees participated in this strike, though by October the number of was reduced to about 24 people.⁶⁸ Meanwhile, Colonel Bumgarner continued to try to improve living conditions while showing decreased tolerance for what officials saw as disruptive behavior.

Fearful that some of the detainees would die, authorities brought in additional medical staff from naval hospitals in Florida to assist in tube-feeding hunger strikers. During a visit of medical organizations to Guantánamo in October 2005, the groups were told that 25 prisoners were currently on a hunger strike, 22 of whom were being fed by nasogastric tube, most of them while in their cells and almost all of them acquiescing to the procedure.⁶⁹

Detainee accounts from this period, many of which are contained in declarations from court cases, dispute some of the statements in Captain Edmondson’s declaration. For example, as of 2005, official practice was to use a size 10 French or a size 12 French feeding tube, one-eighth and one-seventh of an inch in diameter, respectively, though Captain Edmondson acknowledged that for two days larger tubes were used as well.⁷⁰ On insertion of the nasogastric tube the patient is supposed to have been offered viscous lidocaine (a topical anesthetic) for the nostril and throat and the tube is supposed to have been sterilized and lubricated. One detainee claimed that the extraction of the tubes was so painful that it sometimes resulted in blood gushing out, leading to fainting. One detainee alleged that lesions and bleeding occurred when guards held him by the chin and hair while strapped down as a medical staffer “forcefully inserted the tube in his nose and down his throat.”⁷¹

Abdul-Rahman Shalabi claimed that a U.S. Navy doctor inserted the nasogastric tube in his throat and kept moving the tube up and down until finally he started violently throwing up blood. The declaration of his lawyer states: “Abdul-Rahman tried to resist what he called the ‘torture’ from this physician but he could not breathe. He was suffocating and when the tube that had been jabbing him internally was finally removed, it was full of blood.”⁷² Some detainee accounts describe nasogastric tubes being forcibly inserted with no local anesthesia or sedative.⁷³

The Task Force cannot resolve the conflicts in the accounts between detainees and Captain Edmondson. Although the accounts differ with regard to the degree of pain or discomfort associated with practices, there is some agreement, e.g., that bleeding and nausea sometimes occurred and there was one case of loss of consciousness by a detainee. Another example of some confluence of accounts, though again with differences in the consequences, concerns the re-use of feeding tubes. The Guantánamo Joint Task Force standard operating procedure in 2005 required the use of new sterile nasogastric tubes at every feeding,⁷⁴ but a detainee’s lawyer recounts one report that “in front of Guantánamo doctors—including the head of the detainee hospital—the guards took a nasogastric tube from one detainee, and with no sanitization whatsoever, re-inserted it into the nose of a different detainee. When these tubes were re-inserted, the detainees could see the blood and stomach bile remaining in the tubes.”⁷⁵ The account names the medical person who is alleged to have stood by and watched these procedures with no intervention (the publicly released record is blacked out). Captain Edmondson’s declaration, while denying that guards had a role in insertion of nasogastric tubes, acknowledged that tubes had been re-used for the same detainee, but said that the practice was stopped, and also that minor bleeding and nausea could occur on insertion or removal of the tubes.⁷⁶

There is, however, a major difference between Captain Edmondson’s and detainees’ accounts on the role of guards, as detainees dispute Captain Edmondson’s unequivocal claim that guards had no role in inserting and removing tubes. One detainee reported that doctors were present as riot guards removed nasogastric tubes from a detainee’s nose by “placing a foot on one end of the tube and yanking the detainee’s head back by his hair.”⁷⁷ Given the guards’ other roles in force-feeding, including forced cell extraction (the use of a group of guards to forcibly remove a detainee from his cell), the Task Force finds it credible that guards were involved in inserting and removing tubes in some cases.

2005-2006: THE INTRODUCTION OF ROUTINE USE OF RESTRAINT CHAIRS

During the hunger strikes in the fall of 2005, officials concluded that the hunger strikers were not suicidal⁷⁸ or in immediate medical danger.⁷⁹ Some officers, however, believed that the detainees who were being force-fed were treated too leniently, even coddled, as they lived in a comfortable hospital with air-conditioning and had a choice of lozenges to ease the pain of the feeding tubes. They also believed the detainees were trying to undermine the force-feeding process. According to Captain Edmondson, on October 1, 2005, a detainee removed his feeding tube and incited seven other detainees to do the same. A few of the detainees figured out how to siphon food from their stomachs by sucking on the tubes, others vomited after they had been fed, and some were becoming seriously malnourished. Captain Ronald Sollock, who became the Joint Medical Group commander in January 2006, later stated that the hunger strikes unduly burdened the medical staff, who he claimed often had to spend 15 hours a day feeding detainees.⁸⁰

Captain Sollock characterized the approach to hunger strikes at the time as a “failure” because detainees tried to remove their nasal tubes or struck medical personnel administering feeding.⁸¹ The government argued in court challenges to force-feeding that “some” hunger strikers were assaultive during attempts to feed them enterally,⁸² though Captain Edmondson’s 2005 declaration characterizes that number as very low.

From the record available to the Task Force, it appears that in late 2005, dissatisfaction with handling of hunger strikers, including the forms of force-feeding then in place, led policy and practice in responding to hunger strikes at Guantánamo to change dramatically. In early December 2005, Guantánamo administrators brought in five restraint chairs that they claimed were needed to prevent detainees from disgorging food and to make force-feeding more controlled; another 20 restraint chairs arrived in January. A court later noted that the government acknowledged that the restraint chairs used straps to tightly restrain the detainee’s arms, legs, chest, and forehead.⁸³

Once the detainee was immobilized in a restraint chair, medical staff would insert the nasogastric tube via the esophagus into the stomach and administer liquid nutrients over a period of around 30-50 minutes. The detainee would often remain immobilized for a further 60-90 minutes. This additional period was introduced to prevent the prisoner from using the outside end of the nasogastric tube as a “straw” to siphon off the contents of his stomach before it was digested. The force-feeding procedure was performed twice a day on each detainee. It was

a drastic change from the process Captain Edmondson described in his October 2005 affidavit, moving from involuntary or forced feeding, which itself was not consistent with the original Declaration of Malta, to a regime of forced feeding combined with physical restraints. At Guantánamo the use of restraints in the course of force-feeding became routine, as the government acknowledged and a court later found, stating that “it is standard policy to use the restraints on all hunger striking detainees.”⁸⁴

The use of the restraint chairs represented more than a means to address detainees’ resistance to eating or improved security. From the evidence available to the Task Force, it appears to have added a punitive dimension to force-feeding. In December 2005, a U.S. Navy forensic psychiatrist and three experts from the Bureau of Prisons who were brought in to assess the situation argued that the hunger strikes were a discipline issue and that the failure to eat was a violation of camp rules.⁸⁵ In addition to employing the restraint chair, hunger strike procedures require placing the detainee in administrative segregation in a single occupancy cell;⁸⁶ some of the detainee leaders were sent to another unit at Guantánamo where they were kept in isolation 22 hours a day.⁸⁷ Lawyers for detainees said that other measures introduced around this time included placing hunger strikers in uncomfortably cold air-conditioned isolation cells, depriving them of comfort items like blankets and books, and using riot-control soldiers to insert the nasogastric tubes.⁸⁸ These measures were applied to the prisoners without their having committed any disciplinary offense, other than the pursuit of their hunger strike.

Detainees also reported that the restraint chair was invoked as a threat if they continued a hunger strike. One detainee, Fawzi al-Odah, reported that an officer read him an order from General Jay W. Hood that hunger strikers who declined to drink liquid formula voluntarily would be strapped into metal chairs and tube-fed. The detainee told his lawyers he heard “screams of pain” from a hunger striker in the next cell as the nasogastric tube was inserted and so abandoned his hunger strike.⁸⁹ Another lawyer reported that his client, Jum’ah al-Dossari, “understands that officers told the hunger strikers that if they challenged the United States, the United States would challenge them back using these tactics.”⁹⁰

Colonel Bumgarner, who had sought to negotiate with the detainees and improve conditions, now embraced the more coercive approach to counter what he saw as the detainees’ strategy to close the prison and secure their release. He told *Time* magazine, “We used to over-react, and the detainees saw that we got worried if they were not eating.” But, he said, “Now we have a system. I tell them, ‘Have at it. If you want to have 460 hunger strikers, we’ll get

460 doctors in here to take care of you.’ They will not succeed.”⁹¹ Rear Admiral Harry Harris, Jr., who took over command of the Joint Task Force in April 2006, was emphatic that hunger strikes were a tactic in trying to force the United States to back down in its fight against al Qaeda and would not be tolerated. “The will to resist of these detainees is high. They are waging their war, their jihad against America, and we just have to stop them.”⁹²

Captain Sollock, the chief physician, concurred. “We had to take steps to prevent that, but we only do what is medically necessary in a humane and compassionate manner.”⁹³ Although officials also claimed the restraint chair was essential to prevent detainees from dying, two medical officers told the *New York Times* that only a few of the detainees subject to its use were in immediate medical danger.⁹⁴

The newly punitive response to hunger strikes was endorsed by senior officials at the DoD. Dr. Winkenwerder, the highest-level civilian official involved, responded to criticism of the practice by ignoring the issue of restraints altogether, instead seeking to frame the issue as pitting the preservation of life against the death wishes of detainees: “There is a moral question. Do you allow a person to commit suicide? Or do you take steps to protect their health and preserve their life?”⁹⁵ Other officials were more forthcoming about the purpose of the restraint chairs. In an interview with the *New York Times*, General Bantz Craddock, head of the U.S. Southern Command, while claiming that the restraint chairs were “not inhumane,” “left no doubt, however, that the authorities had decided to try to make life less comfortable for the hunger strikers, and that the measures were seen as successful.”⁹⁶ Admiral Harry Harris, who took over command of Guantánamo in April 2006, characterized detainees committing suicide as engaging in asymmetric warfare. He told *TIME*, “We are humane and compassionate, but if we tell a detainee to do something, we expect the detainee to do it.”⁹⁷

The restraint chairs initially had their intended effect: the number of hunger strikers declined from 84 to 4 by the end of December 2005.⁹⁸ By February 2006, the *New York Times* reported that the restraint chair had been used to force-feed 35 detainees. Officials claimed that their strategy was working. Whether it was indeed working remains uncertain, as in the spring of 2006 there were more riots and then three deaths that the DoD has characterized as coordinated suicides at Guantánamo.

The introduction of the restraint chair and accompanying means of coercion introduced an entirely new chapter in the history of responses by prison administrators to hunger strikes. Prisoners had been force-fed in the past, at Guantánamo and elsewhere, in the sense that eating was involuntary, a practice

itself deemed unethical by the World Medical Association and other authorities. But now the process of force-feeding included punitive elements of restraint and even violence inflicted on the detainee. Further, there was no pretense of seeking to address the underlying sources of the detainee's protest, or of ensuring the medical independence of physicians or their role as intermediaries. On the contrary, the medical staff participated directly in the routine use of the restraint chair in order to enterally feed the detainee.⁹⁹

Medical staff, by command-level protocol, became engaged in a process of directly inflicting torture or cruel, inhuman, or degrading treatment on detainees strapped in the restraint chairs. Physicians who would not participate in forced feeding on ethical grounds were screened out to prevent their deployment to Guantánamo.¹⁰⁰ If there was any doubt that such screening practice was the exact opposite of what the Declaration of Malta requires, that doubt was removed by revisions to the declaration in 2006, soon after the new procedures were put into place: where "a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal."¹⁰¹

Detainees consistently reported suffering in the new force-feeding process. Even in the best of circumstances, as where a physician consulting for a detainee's lawyer witnessed the procedure, use of the restraint chair was very unpleasant. Dr. Emily Keram, who evaluated detainee Ahmed Zaid Slaim Zuhair in April 2009, witnessed a feeding and provides a detailed description of the procedure, following the standard protocol:

*Once Mr. Zuhair was in the chair, restraints at the ankles, waist, wrists and a shoulder harness were placed by the guards. The restraints are made of material similar to an airline seat belt. The feeding tubes used at the time of the evaluation were 10 French (small bore). The nurse dipped the tube in olive oil prior to insertion as the lubricant caused Mr. Zuhair discomfort Tube placement was checked with a stethoscope using air and confirmed with a small water bolus. A bag containing the feeding solution was attached to the feeding tube. The rate of delivery was controlled by a stopcock mechanism. Mr. Zuhair would tell the nurse when the rate needed to be adjusted for comfort. He would be kept in the restraint chair for 15-30 minutes after the solution was administered to facilitate absorption.*¹⁰²

As this account shows, some doctors and nurses sought to minimize the discomfort to detainees from what is inevitably a very uncomfortable procedure.

But for some detainees, force-feeding was experienced as a series of violent assaults resulting in what they described as excruciating pain. Physicians were either present or directly involved in many of the practices. The process began with forcibly removing the detainee from his cell. Medical personnel were often present at that time. One detainee kept in isolation described how an officer told him that if he would not eat solid food, he would be force-fed in the restraint chair. When he declined, he said, guards "picked him up by the throat, threw him to the floor and strapped him to the restraint chair."¹⁰³

The medical note signed prior to such a force-feeding stated that a prisoner can expect to spend up to 60-120 minutes restrained.¹⁰⁴ The inability to move for long periods of time while being force-fed was agonizing for many detainees. There are also multiple accounts of detainees being left in restraint chairs for hours at a time to urinate and defecate on themselves, despite pleas to use the bathroom.¹⁰⁵

According to Captain Edmondson, the procedure required doctors to carefully and continuously evaluate the rates of gastric feeding and hydration of detainees, given that each patient will vary in ability to accept differing amounts of hydration and nutrition.¹⁰⁶ Detainees, however, made repeated allegations of being given too much dietary supplement, causing them to vomit.¹⁰⁷ One detainee describes being forced to consume an entire carton of Ensure, a liquid dietary supplement, causing him to vomit so violently that he ejected the end of the feeding tube that had been in his stomach.¹⁰⁸ Detainees had no means of resisting the forced ingestion of excessive amounts of Ensure.¹⁰⁹ It is no surprise, then, that detainees viewed the restraint chair as a deliberate effort to torture them and was characterized by one detainee as the "execution chair."¹¹⁰ Another stated that the restraint chair caused him to feel "like an animal," not a person; the restraint chair took away his "honor and dignity."¹¹¹

Other concerns raised in medical declarations relate to the longer-term medical consequences of the force-feeding protocols on detainee health. Abdul Rahman Shalabi, who had, as of September 2010, been on continuous hunger strike for five years, exhibited medical complications that can result from extended periods of enteral feeding and repeated insertions of a nasogastric tube. His symptoms included serious inflammation of the nasal passage and gastrointestinal complications.¹¹² On independent medical evaluation he was also found to be suffering from post-traumatic stress disorder and exhibiting signs of major depression as a result of his treatment.¹¹³ Ahmed Zaid Salim Zuhair, who was also on hunger strike for five years, was described in an independent medical report by Dr. Keram as suffering from coccydynia, which is pain in the tailbone, and hemorrhoids, which are exacerbated by use of the restraint chair; she

also found that his symptoms of anxiety and depression were exacerbated by the use of the chair.¹¹⁴ The accounts of detainee lawyers also indicate that the detainees on hunger strike even for more limited periods of time had clinical complications connected with force-feeding, mainly relating to pain and hoarseness of the throat and in some cases visible swelling of the arms from attempts to insert an IV.¹¹⁵

The government denied the accuracy of these claims,¹¹⁶ but the claims of torture by detainees through force-feeding in restraint chairs were never adjudicated, as a court hearing the case deferred to Guantánamo administrators, stating that, “Resolution of this issue requires the exercise of penal and medical discretion by staff with the appropriate expertise, and is precisely the type of question that federal courts, lacking that expertise, leave to the discretion of those who do possess such expertise.”¹¹⁷

By early 2006, however, after media reports of the use of the restraint chairs and their impact on detainees, medical organizations began to protest. A letter from more than 250 prominent physicians appeared in the *Lancet*, one of the premier medical journals in the world, in March.¹¹⁸ The same month the American Medical Association issued a critical statement¹¹⁹ in which Dr. Duane M. Cady, chair of the association’s board of trustees, quoted from the World Medical Association standards: “...where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he shall not be fed artificially.”¹²⁰

Later in the year, the Islamic Medical Association of North America, asked by the DoD for its views, referenced the prohibition against suicide in Islam but called on the United States to follow the World Medical Association and American Medical Association ethics analysis, calling force-feeding a form of inhuman and degrading treatment and the use of restraint chairs a form of torture.¹²¹ The use of restraints also raises the question of whether that practice was inconsistent with requirements of the UN Principles of Medical Ethics, which provide that it is a violation of medical ethics to use physical restraints on a prisoner without a determination that it is necessary for the protection of the physical or mental health of the prisoner or the safety of the prisoner or others.¹²²

At the same time, the DoD was in the midst of a high-level policy review of medical practices affecting detainees. In June 2006, as protests from medical groups continued and the revisions to the Malta Declaration were under consideration by the World Medical Association, the Assistant Secretary of Defense for Health Affairs issued a new instruction on medical support for

detainee operations.¹²³ The instruction justified force-feeding by equating hunger strikes with attempted suicides or other efforts at serious self-harm, and said that treatment may be directed without the consent of the detainee when “immediate treatment” is needed to “prevent death or serious harm.” No reference is made to hunger strikes as protests against conditions or circumstances of confinement. As before, the recommendation was also subject to approval of the “senior officer responsible for detainee operations.”¹²⁴ This instruction remains in effect today.

The Task Force believes a number of features of the instruction are worthy of note. First, it ignores clinical information about hunger strikes, including the recognition by medical staff in 2002 that hunger strikers could fast for many weeks without jeopardizing their lives and the record that hunger strikers were not suicidal. Indeed, the instruction contains no recognition that in most cases no clinical harm whatsoever exists during the initial period of a hunger strike. Second, consistent with this omission, it leaves the meaning of “prevent death or serious harm” undefined, leaving it unclear when force-feeding can be started. Third, despite its apparently medical approach, it affirms that the decision to force-feed is not a medical one, as the commander of the detention center is assigned the final decision, thus undermining the very claim that the action was about saving lives.¹²⁵ Fourth, the instruction contains no reference to any effort to respect detainee autonomy, even where life or health is not under threat, as the 2003 and 2005 policies did. Fifth, it makes no explicit mention of the use of force or the restraint chair, leaving the practice entirely unregulated by civilian leadership, even though routine use of the restraint chair ignores a provision in the same instruction that requires restraints only be used where it is determined that they are necessary for the health or safety of the detainee or others.¹²⁶ The omission is important because, when introduced, restraint chairs were used for all enteral feedings unless there was a medical reason for refraining to do so.¹²⁷

Officials claimed at the time and have claimed since that the policy was modelled on the policy of the U.S. Bureau of Prisons, which permits involuntary feeding.¹²⁸ The Task Force is of the view that the Bureau of Prisons policy is inconsistent with the requirements of the Declaration of Malta because of its endorsement of forced feeding. There are, nevertheless, key differences between the Bureau of Prisons approach and that of the DoD:

- Bureau of Prisons practice assigns control of responses to hunger strikes to physicians, based on individual circumstances and good medical practice, whereas at Guantánamo it is the commanding officer who has ultimate authority on force-feeding.

- Force-feeding is not initiated by the Bureau of Prisons from the inception of a hunger strike; in one reported case, it took six weeks before force-feeding was considered.¹²⁹
- Bureau of Prisons regulations provide that the use of restraints is permitted only in cases of specific behaviors limited to assaults, destruction of property, attempted suicide, injury to oneself, or violence or showing signs of imminent violence.¹³⁰
- Bureau of Prisons regulations make no provision for routine or categorical use of restraints generally or to use of restraint chairs for force-feeding.¹³¹ According to the U.S. government's 2005 report on its compliance with the Convention Against Torture, "the [Bureau of Prisons'] use of restraint chairs is intended only for short-term use, such as transporting an inmate on or off an airplane."¹³²
- Bureau of Prisons regulations state that the use of four-point restraints (five-point restraints are not contemplated) is only permitted where the warden determines that "they are the only means available to obtain and maintain control over an inmate" and other conditions are met.¹³³
- Bureau of Prisons regulations make no reference to use of force-feeding as a form of discipline or control of inmates.
- Safeguards are in place to protect inmates, including policy that:
 - a** Requires the warden to notify the sentencing judge of involuntary feeding, with an explanation of the background of and reasons for involuntary feeding¹³⁴
 - !** Requires videotaping of force-feeding¹³⁵
 - !** Provides access to counsel and legal remedies for abuses in the force-feeding process
 - I** Requires review by an appropriate court be sought in advance if force-feeding through surgery in the abdominal wall—called a gastrostomy—is used¹³⁶

Finally, the Bureau of Prisons requires that "treatment is to be given in accordance with accepted medical practice."¹³⁷ By contrast, DoD does not expect physicians to make judgments about detainee capacity, a fundamental duty originating in respect for the patient as well as the voluntariness of the detainee's

decision. DoD claims that it is "extremely difficult" for clinicians to make such an assessment, including whether detainees are under orders from other prisoners, so eschews them altogether and opts instead for a blanket policy of force-feeding.¹³⁸ DoD also prevents physicians from occupying the role of counselor to the detainee, as its "counseling" consists only of encouraging the detainee to eat and reciting that force-feeding is a result of orders from above. In his 2005 declaration, Captain Edmondson stated, "One of my physicians met with the detainee patients and explained again why involuntary feeding was being done and that the involuntary feeding was authorized through a lawful order of a higher military authority"¹³⁹—a frank acknowledgement that medical judgment was superseded by military ones.

In sum, the Bureau of Prisons physician continues in his or her role as physician and healer, whereas the physician engaged in force-feeding at Guantanamo is acting as an agent of the security apparatus.

In discussing the 2006 policy, Dr. Winkenwerder continued to claim that the policy was based on preserving life, even suggesting that the case of hunger strikers at Guantanamo was like the then most famous feeding case in the United States, the Terri Schiavo case, where the question was whether to continue feeding a comatose woman.¹⁴⁰ That case was nothing remotely like force-feeding competent prisoners over their overt objections. The relationship between the artificial feeding of Terri Schiavo and the realities of force-feeding at Guantanamo could not have been starker: whereas a claim was being made to feed in the name of health, DoD practice has been to engage in acts that inflicted pain and punishment on detainees.

DoD did not want hunger strikers to die, but the Task Force concludes that even if its policies were based in part on the preservation of detainees' lives, they have been severely tainted by the security aim of gaining control over detainees and defeating hunger strikes, the coercion used to achieve it, and the undermining of medical care. The role of physician as trusted intermediary and source of advice was transformed into the role of physician as agent of detention authority, in violation of the duty of beneficence as reflected in professional standards and in UN requirements.¹⁴¹ The statement of the Islamic Medical Association, which was sympathetic to the view that detainees should not be allowed to die, captured how the practice at Guantanamo was inconsistent with sound medical practice and ethics.

Such people [hunger strikers] should be given full access to medical care, pastoral care, and mental health services to best address the intentions of their actions and to counsel them on the grave consequences of suicide in

*Islam. Notwithstanding our support for the view of the cited medical bodies, we would consider life supporting measures in such very limited and extreme circumstances only after a thorough medical and mental health evaluation with independent supervision and observation, which to our knowledge do not currently exist in Guantánamo.*¹⁴²

As noted above, revelations about U.S. practices, together with concerns raised in response to hunger strikes in Turkey, led the World Medical Association in the fall of 2006 to adopt even more explicit standards against force-feeding, accompanied by a detailed background paper.¹⁴³ Though the association took a firm position against force-feeding, and specifically condemned the use of restraints in force-feeding as inhuman and degrading treatment, the DoD did not further review its policy, and does not follow the Malta standards. As a result, the DoD requires military physicians to violate internationally accepted medical ethics standards.

After many procedural delays, in 2009 a federal court considered the claims of detainees dating to 2005 and 2006 that force-feeding and the use of the restraint chair violated their rights under the U.S. Constitution. It found that the use of the restraint chair was “standard policy,”¹⁴⁴ but as noted above declined to adjudicate the claims of the detainees, as it believed intervening court decisions prevented it from addressing claims by detainees at Guantánamo about their conditions of confinement. It held no evidentiary hearing. At the same time, it accepted at face value the claim by the DoD that commanders were acting to preserve the life of detainees and that they had determined that the use of the restraint chair was necessary to achieve that end and that no less restrictive means were available.¹⁴⁵

As the preceding discussion shows, however, the court was mistaken in accepting those representations, not only because they were not subject to a hearing and cross-examination, but because there is nothing in the existing record about DoD policy and practices regarding hunger strikes to support them. The court also noted in passing that the DoD had vetted the use of restraint chairs with the Bureau of Prisons, but here, too, the court’s jurisdictional decision led it not to explore the comparison between policies and practices of the DoD and the Bureau of Prisons. Nor did it address the requirements of the Declaration of Malta regarding the role of physicians in force-feeding.

HUNGER STRIKE POLICY 2007-PRESENT

Hunger strikes, force-feeding, and the use of restraint chairs have continued since they were adopted in 2006. The first protocol the Task Force was able to

obtain after the 2006 instruction is a declassified 2008 medical care standard operating procedure for the Bagram military facility in Afghanistan,¹⁴⁶ which can be read along with a court declaration filed in 2008 by the Joint Medical Group commander and the Joint Task Force surgeon at Guantánamo.¹⁴⁷ It recognizes, consistent with knowledge in the field but contrary to assertions by DoD leadership, that hunger strikes are initiated “as a form of protest or to demand attention,”¹⁴⁸ rather than as suicidal behavior or self-injurious behavior.¹⁴⁹ Except in the context of a mental health evaluation, however, the operating procedure does not call for any effort to understand, much less address, the reasons for the protest, and eschews any attempt by either command or the primary health care provider to resolve the detainee’s concerns. Rather, the entire policy is designed to end the hunger strike either by convincing the detainee to abandon the hunger strike or, if that fails, by force. Doctors and nurses play a part in carrying out this policy.

The Task Force notes that the protocol reflects tension between appropriate medical management and subordination of medical considerations to security functions. While there are expressions of alleged concern for the “health and welfare of hunger striking detainees,”¹⁵⁰ the primary objective is to convince or coerce the detainee to end his protest by eating. As in past policies, non-medical military authorities make decisions to initiate or end force-feeding, thus constraining the roles of physicians and nurses. Further, according to the procedures, a hunger striker is immediately put in administrative segregation, a punitive response. If the detainee refuses to undergo an examination, he may be forced to do so by order of the head of all detention and operations, the guardian commander. Medical personnel participate in the effort to break the strike. The mental health staff is also assigned the duty to conduct “behavioral interventions to persuade the detainee to resume eating.”¹⁵¹ These interventions include offering the detainee “tempting food,” and situating him with small groups “to create peer pressure to eat.”¹⁵² The medical staff is assigned the task of notifying the detainee of risks of not eating and trying to dissuade the detainee from continuing the fast. At no point are the health professionals advised to use independent medical judgment to ascertain the detainee’s wishes and plans, nor to counsel the detainee about his course of action.

If efforts to convince the detainee to eat are not successful, the medical officer may recommend involuntary treatment and feeding.¹⁵³ According to the procedures, force-feeding should be considered if any of the following clinical criteria are met: evidence of deleterious health effects reflecting end organ damage; pre-existing condition that could lead to end organ damage; the hunger strike has been ongoing for 21 days; the detainee weighs less than 85

percent of ideal body weight; the detainee has experienced 15 percent weight loss. On the other hand, it permits force-feeding through many methods, including forced enteral feeding through nasogastric tubes, intravenous administration of high-nutrition solutions, and the use of feeding through surgically established access into the stomach through the abdominal wall.

Although the protocol is not clearly written, it appears that force-feeding was initiated in the hospital. According to the protocol, after six or more days of hospital feeding, the detainee can be moved to the cell block at the discretion of the medical officer for either voluntary eating or intermittent enteral feedings two to three times a day. If the hunger striker continues to refuse to eat, the protocol authorizes and recommends the use of restraints: “Medical restraints (e.g., chair restraint system) should be used for the safety of the detainee, medical staff, and guard force.”¹⁵⁴ The medical provider has the authority to order the use of restraints. In that case, the guards offer the detainee restroom privileges and then shackles are placed on him and a mask is placed over his mouth to prevent spitting and biting. He is weighed and then “escorted to the chair restraint system and is appropriately restrained by the guard force.” When the guards advise that it is safe, medical personnel initiate medical restraint monitoring, recording his condition every 15 minutes. A feeding tube is placed in the detainee through the nose using viscous lidocaine. If there is sufficient staff available, the detainee is removed from restraints after feeding is completed, usually after 20-30 minutes, and placed in a “dry cell,” where no water is available, for observation on whether he is vomiting or is trying to induce vomiting. If sufficient staff is not available, the detainee will be kept in the restraint chair for up to two hours.

Although the protocol is not entirely clear, it appears to call for the routine use of the restraint chair in every case of enteral feeding. Captain Bruce Meneley’s 2008 declaration suggests that this was the practice in Guantánamo at the time, as he notes that the detainees were fed in restraint chairs in a common area in front of their cells.¹⁵⁵ The 2009 court decision also referred to the use of restraint chairs as standard policy.¹⁵⁶ In early 2009, a news report stated that 10 percent of detainees at Guantánamo were being force-fed.¹⁵⁷

Admiral Walsh’s 2009 review of practices at Guantánamo makes clear that three years after the introduction of the restraint chairs, and use of “forced cell extraction” to move detainees who would not cooperate in force-feeding, these procedures remained in place. His report says that these individuals were fed on gurneys or in restraint chairs without head restraints (which would make the chairs five- rather than six-point restraints), which it claimed were used for the minimum time necessary to protect staff and detainees—but it does not indi-

cate what the typical time is.¹⁵⁸ The report states that many of the chairs were outfitted with pillows and padding for comfort. It also says that restraint chairs were used when deemed necessary by medical personnel.¹⁵⁹

Admiral Walsh declared that force-feeding policy and practice was humane, accepting the position articulated by the DoD that it was “conducted solely as a medical procedure to sustain the life of and health of hunger strikers.”¹⁶⁰ According to his report, if the detainee chose not to eat, the physician was instructed to continue evaluations until there was a “significant threat to life or health if the fasting were to continue.”¹⁶¹ The report did not consider the significance of the routine use of force-feeding and the restraint chair for months at a time. Although it cited nongovernmental organization demands that World Medical Association policy be followed, it did not address that concern, nor the ethical implications for physicians and nurses in implementing DoD policies.

The Task Force is troubled by Admiral Walsh’s lack of in-depth review of force-feeding policies and practices,¹⁶² by the sunny picture he presents of the use of restraint chairs and forced cell extraction, and by his lack of attention to medical ethics. Far from being humane, the use of force-feeding over the past decade violates the human rights of detainees and has led physicians and nurses to commit serious breaches of their professional standards. Moreover, detainees have been force-fed for weeks and months at a time. The Task Force is not aware of any precedent for “managing” hunger strikes for such a long period, lasting over months, and in some cases years.¹⁶³ Neither the World Medical Association nor any standard-setting authority ever contemplated multiple force-feedings in a restraint chair over the course of weeks, much less months and years, as has been the practice at Guantánamo. The Task Force joins others in concluding that the practice of force-feeding in restraint chairs over the course of months, depending on the exact circumstances, amounts to torture or inhuman and degrading treatment.

In April 2011 there was a report of another coordinated hunger strike in progress.¹⁶⁴ Additional hunger strikes were reported in 2012.¹⁶⁵ In March 2013, the Joint Medical Group at Guantánamo adopted a new standard operating procedure (SOP) on medical management of hunger strikes¹⁶⁶ that follows the contours of the 2008 Bagram policy and also makes certain key changes to it.

- The SOP explicitly views hunger strikes as a security issue, analogizing adjustments to responses to hunger strikes to needed changes in battlefield tactics. It notes, too, that because some detainees have been on hunger strikes since 2005 and are chronically malnourished, a new operating procedure is needed “to reflect current tactics and practice.”

- The SOP makes clear that while the articulated policy is to “protect, preserve and promote life,” the role of medical personnel is to serve the interests of command. Doctors and nurses do not act with medical independence. Rather, the SOP states that effective management of hunger strikes “requires a partnership between the [Joint Medical Group] medical staff and the Joint Detention Group (JDG) security force.” As in the past, the final decision whether to force-feed a detainee is made by the Joint Task Force commander, not a physician, and must be in writing. The command also determines places and times of feeding.
- Consistent with this approach, after a hunger strike has begun (defined as communicating an intent to be on a hunger strike, missing nine consecutive meals, or weight loss to a level lower than 85 percent of ideal body weight), the initial role of medical personnel is limited to a medical evaluation, explaining the medical consequences of a hunger strike to the detainee, and making recommendations to command on force-feeding and the need for hospitalization. The SOP makes no provision either for an evaluation of the detainee’s competence or capacity, or for the physician to counsel the detainee on options.
- The SOP calls for the Behavioral Health Service to perform an assessment of the mental and psychological status of the detainee, but says nothing about how this information is used to make decisions about addressing the hunger strike. Ongoing medical evaluation, which is required, does not provide for review of capacity or mental state.
- The SOP reiterates, in slightly different form, the five grounds for permitting forced enteral feeding contained in the Bagram SOP. To recommend force-feeding, the medical officer must also state that involuntary feeding is necessary to prevent risk of death or “serious harm to health.”
- The SOP states that chair restraints should be used for enteral feeding “for the safety of the detainee, the medical staff, and the guard force.” The restraint chair may be used twice a day for up to two hours each time, including post-feeding observation. Placement in the restraint chair is done by the guard force. Medical personnel monitor the individual’s condition every 15 minutes.
- Detainees who are “chronic enteral feeders” and who agree to be fed that way may receive enteral feedings in medical clinics or media rooms in communal settings with a single restraint.

- In a major policy change from the past that adds to the coerciveness of force-feeding, the detainee is no longer permitted to control drip rates or order of ingredients during enteral feeding. In 2005, Captain Edmondson had stated that “detainees retain a large measure of control over the administration of nutrition” and that the detainee subject to enteral feeding “controls the flow of nutrition so that discomfort is minimized.”¹⁶⁷ The new SOP states that such control “has had the effect of prolonging the total time spent in the feeding chair and has given the detainee a measure of control over an involuntary process.” All elements of detainee control over flow rate, content of feeding, or location of feeding is now prohibited.
- Feeding solutions are ordered by a physician and enteral feeding is administered by a nurse. In light of the rules depriving detainees of any control of feeding, the nurses’ judgment and independence is severely constrained. The SOP provides stock responses nurses should make to detainee questions and complaints that deny them the ability to make affirmative responses to requests. For example, if the detainee asks to see a doctor, the nurse is to respond, “I will write a note in your chart for the doctor.”

Around the time the new policy was issued, a mass hunger strike began. Although the origins of the mass hunger strike are disputed, it appears to have initially been a result of detainees’ despair over lack of prospect of transfer even if they had been cleared to go to another country. By March 15, the official count of hunger strikers was 14. It rose to 21 by March 18 and reached 25 by March 20. Eight of the 25 were force-fed.¹⁶⁸ A week later, there were a total of 33 hunger strikers, representing 19 percent of the detainees; 11 were being force-fed and three were hospitalized.¹⁶⁹ By April 11, the number reached 43, and the president of the ICRC publicly urged President Obama to resolve what he called the “untenable” legal situation of detainees held in indefinite detention.¹⁷⁰ Two days later, the situation turned violent, as guards forcibly emptied communal cellblocks, fired non-lethal shots at detainees, and detainees resisted with improvised weapons.¹⁷¹

Meanwhile, a detainee’s experience of force-feeding under the new policy was expressed in an op-ed in the *New York Times* :

Last month, on March 15, I was sick in the prison hospital and refused to be fed. A team from the E.R.F (Extreme Reaction Force), a squad of eight military police officers in riot gear, burst in. They tied my hands and feet to

the bed. They forcibly inserted an IV into my hand. I spent 26 hours in this state, tied to the bed. During this time I was not permitted to go to the toilet. They inserted a catheter, which was painful, degrading and unnecessary. I was not even permitted to pray.

I will never forget the first time they passed the feeding tube up my nose. I can't describe how painful it is to be force-fed this way. As it was thrust in, it made me feel like throwing up. I wanted to vomit, but I couldn't. There was agony in my chest, throat and stomach. I had never experienced such pain before. I would not wish this cruel punishment upon anyone.

I am still being force-fed. Two times a day they tie me to a chair in my cell. My arms, legs and head are strapped down. I never know when they will come. Sometimes they come during the night, as late as 11 p.m., when I'm sleeping.

When they come to force me into the chair, if I refuse to be tied up, they call the E.R.F team. So I have a choice. Either I can exercise my right to protest my detention, and be beaten up, or I can submit to painful force-feeding.¹⁷²

In late April, the American Medical Association wrote to the Secretary of Defense, reiterating its view that “the forced feeding of detainees violates core ethical values of the medical profession.”¹⁷³ By the end of April, more than 100 of the 166 detainees at Guantánamo were on a hunger strike, and 21 of them were being force-fed.¹⁷⁴

In the Task Force's view, the new policy is even more punitive than those employed in the past and exacerbates the features of U.S. hunger strike policy at Guantánamo that already violate international standards. The Task Force further concludes that by entangling physicians and nurses in a punitive approach to hunger strikes and requiring them to depart from duties of respect for patient autonomy and exercise of independent professional judgment, the DoD assigns a role to physicians and nurses that is unethical. The Task Force's conclusion is consistent with decisions of courts reviewing similar practices. The European Court of Human Rights, while stating that force-feeding to save a life may not amount to a violation of laws against torture and cruel, inhuman, or degrading treatment, held that “repeated force-feeding, not prompted by valid medical reasons but rather with the aim of forcing the applicant to stop his protest, and performed in a manner which unnecessarily exposed him to great physical pain and humiliation, can only be considered as torture.”¹⁷⁵ The Task Force agrees

that, depending on the exact circumstances in each case, current force-feeding practices amount to either torture or inhuman and degrading treatment.

Needed reforms

The DoD should prohibit the use of force-feeding, forced cell extraction, and restraint chairs, and restore physicians to the proper role of having a true doctor-patient relationship with detainees engaged in hunger strikes. Taking that course not only is consistent with medical ethics and human rights but can prevent the confrontations that have characterized hunger strikes at Guantánamo.

The DoD should agree to abide by the Declaration of Malta and issue guidance and training consistent with it. Protocols that require the physician's counselling of detainees to consist of little more than notifying him of the medical and security consequences of fasting should be replaced by rules that foster and provide support for an ethics-based physician-patient relationship.¹⁷⁶ The protocols should enable the physician to act with professional independence and autonomy so as to make medical decisions on an individualized basis without control or required approval by security or base officials, including when to feed via a nasogastric tube.¹⁷⁷ Confidentiality of communications must be guaranteed. It is essential that the physicians be trained and instructed to convey from the start that they are not there as prison officials to try to convince the detainee to stop his protest but rather as providers who put the patient's interests first. The protocols should reinforce the duty to convey to detainees that the doctor is present as their physician, to see to their health, to answer any questions they may have, to explain how fasting and metabolism work, but above all to listen and maintain a line of communication with them, and to act out of a genuine concern for their health and well-being.

Rules governing prison operations should change to facilitate the appropriate role of the physician. The physician must be able to meet in private with the hunger striker.¹⁷⁸ Provision should be made for advance directives in the event the detainee loses the capacity to make medical and life decisions.¹⁷⁹ No detainee should be punished or be subject to less advantageous conditions of confinement on account of participating in a hunger strike; if he needs to be separated from others involved, he should be housed in equivalent conditions, not placed in isolation. As trust is essential to appropriate medical care for hunger strikers, other policies that undermine trust, such as sharing medical information with interrogators or participation in interrogation by health professionals (including non-clinicians), should be eliminated.

Procedures and accountability for health professional reporting of abuse must be strengthened. Alternative paths for resolving detainee grievances should be available. Compliance with international norms for prisoner treatment and access to counsel need to be followed.¹⁸⁰ Consistent with the Declaration of Malta, outside medical consultants should be allowed at the request of the detainee or his family.

Prolonged social isolation, often leading to the kind of desperation that produces hunger strikes, should be ended, and indefinite detention, which has been a major driver of hunger strikes,¹⁸¹ should be addressed.

The instructions and protocols establishing physician autonomy should be accompanied by training to help physicians carry out their duties. For example, the physician should be taught to determine whether the hunger striker is alone in his decision, whether he is under pressure, and whether the hunger striker is prepared to accept a fall-back position, accepting much less than initially demanded. The physician should also be trained not simply to counsel the detainee about the medical consequences of a prolonged fast, but in finding a solution, perhaps by lowering the bar of contention or discussing options such as taking vitamins and perhaps other nutrients so as to allow plenty of time for negotiations. If the detainee admits he does not want to continue the hunger strike, he can be counselled about potential options.

If approached in this constructive way, aiming to establish a positive rapport and (hopefully) trust between the physician and the hunger striker, the protestor may agree to receive artificial feeding, thus allowing him not to lose face (by quitting the hunger strike), yet freeing him from danger while a solution is sought. For collective hunger strikes, physicians should be trained in how to speak with each hunger striker individually, and how to ensure development of trust, privacy, lack of punishment or coercion, and confidentiality.

Such practices can also serve to avoid clashes between physicians and authorities or put physicians in situations where they either have to refuse to obey command or abandon ethical practice. It is likely that in the vast majority of cases, these steps will provide a route to addressing the concerns and health needs of hunger strikers. In all circumstances, this course will ensure that the independence of the medical chain of command will be affirmed and reinforced.

Other countries, such as the United Kingdom and Israel, successfully follow this approach. In Israel, the Task Force has been informed by Israeli Medical Association members who are treating hunger strikers that in the last decade thousands of Palestinian prisoners have engaged in hunger strikes. The emphasis in the medical response to hunger strikes is to ensure a doctor-patient relationship based on trust and to help the detainee make decisions about his

course of action and future wishes in the event of loss of capacity. Ethics committees help the physicians address questions that arise during the course of the hunger strike. Taking this approach is considered consistent with Israeli legal requirements for respecting the sanctity of life. While critics cite other ethical and human rights violations in authorities' responses to hunger strikers, criticisms the Task Force has not assessed, force-feeding is prohibited and no prisoners have died.

*Education and training
of military physicians
on treatment of prisoners*

MILITARY PHYSICIANS ARE CONFRONTED with unique ethical conflicts that pit the primacy of the physician-patient or physician-prisoner relationship against military priorities. The most significant of these is dual loyalty—conflicting obligations to patients and a third party. When the third party is the state, patients' human rights are often at risk.¹ Although issues of dual loyalty implicate human rights in certain institutions because of denial of liberty and use of coercion (prisons, mental hospitals), they are especially intense in military settings where the interests of prisoners can be undermined by claims of national security. Formal instruction of physicians, however, may enable them to better distinguish what they owe prisoners as medical professionals from what they owe the military as officers.

This chapter opens with a description of medical school education, both civilian and military, focusing on the content of ethics curricula in each. It then discusses how physicians receive training in medical ethics during residency training (which is known as graduate medical education), basic officer training, and pre-deployment training. It also analyzes teaching and reference materials, including field manuals. The chapter closes with a set of recommendations about educational content and teaching methods that aim to prevent the abuses that occurred at Abu Ghraib, Guantánamo, and elsewhere. It does not cover education of other health professionals, including psychologists, though the recommendations for pre-deployment training apply to all health professionals.

*Ethics education
in civilian medical schools*

The education of a physician takes place over a far longer period of time than the education of other professionals. Medical schools in the United States

require four years of attendance. Residency requires an additional three to five years, depending on whether one wants to be an internist or pediatrician (three years) or a surgeon (five years). Sub-specialty fellowship training of an additional two to four years has now become commonplace. This means that many physicians trained in the United States spend 10 years after completing college learning to become a doctor.

These 10 years of training allow opportunities for learning about ethical issues, such as end-of-life decision-making and informed consent for human experimentation. Ethics education is relatively new to medical school curricula. Three decades ago, few U.S. medical schools offered courses in medical ethics. The patients' rights movement of the 1970s and the scandals in human experimentation, including decades-long experiments in which African American men were denied effective treatment for syphilis, among other social and political events, fomented the change. Fallout from the 1976 case of Karen Ann Quinlan, a young woman hospitalized in a persistent vegetative state, stimulated the inclusion of end-of-life decision-making as part of medical school ethics courses.

Progress in establishing such courses has been uneven. While the overwhelming majority of medical school deans (94 percent) believe ethics courses should be mandatory, individual schools' commitment to ethics education varies widely. Twenty percent of schools provide no funding for ethics education, and only 55 percent require an introductory ethics course for all students.² Even when ethics courses are academically rigorous and provide excellent content, the material is easily forgotten when physicians enter practice. Because ethics does not constitute a subject on any board examination, there are no sanctions for ignorance.

Even more important, formal coursework on issues of human rights and the problems of dual loyalty for physicians—whether working in the military, corrections, mental health, or corporations—are only now beginning to attract attention in ethics education. In the wake of allegations of physician participation in torture at Abu Ghraib, a survey conducted in 2007 asked deans of U.S. medical schools about barriers to implementing ethics courses that included international human rights and the role of physicians in armed combat. Less than one-third of the medical schools offered teaching on health and human rights. Of those that did, less than one-half offered courses for credit. The vast majority of medical school deans (88 percent) said that there was no time in the curriculum for this material, although 80 percent acknowledged that there was student interest, and virtually all administrators (98 percent) believed that health and human rights was an appropriate subject for medical students.³

Medical ethics education in the military

There are two parallel systems of undergraduate military medical education. The vast majority of military physicians on active duty are graduates of civilian medical schools. Many of these physicians are in the military as part of the Health Professions Scholarship Program, a loan repayment plan in which one of the branches of the military (U.S. Army, Navy, Air Force) pays the student's medical school tuition, and a small stipend, in return for four years of service after residency training (and fellowship training if so desired). The average physician remains on active duty for an additional 4.6 years after completion of mandatory service.

Parallel to this military-funded civilian medical school education, the U.S. military operates one medical school, the Uniformed Services University of the Health Sciences (USUHS). Established by Congress in 1972, USUHS is under the supervision of the Department of Defense (DoD) and mandated to graduate no fewer than 100 medical students annually.⁴ The school educates physicians dedicated to career service in the DoD and the U.S. Public Health Service, with the formal objective of creating *military* physicians. Tuition at USUHS is free, and students are paid a stipend and base pay while in school, averaging around \$52,000 per year.⁵ Over the last decade, USUHS has graduated an average of 167 students per year. By 2010, 3,912 physicians had graduated from USUHS and 75 percent of them remain on active duty.⁶ Eighty percent of USUHS graduates are satisfied with their medical education, compared with a third of those who received their medical education in civilian medical schools under the Health Professions Scholarship Program.⁷

The military medical system is geared to train physicians to provide medical care to men and women in the military, their families, and their dependents. Deployment to a combat zone comprises a small fraction of any military physician's career. Medical care on U.S. territories is provided in more than 20 military medical centers, the largest of which are in Washington, DC, and San Antonio, Texas. Military medicine is distinct from the Veterans Affairs system. The medical education of a military physician is divided into four years of undergraduate medical school and three to six years of post-graduate education (residency training with or without sub-specialty training). Pre-deployment training lasts three to six weeks before military physicians ship off with their units to combat zones.

The curriculum at USUHS is 700 hours longer than the curriculum at other U.S. medical schools. The extra hours cover epidemiology, tropical diseases, leadership, field exercises, and other requirements that are especially relevant

to USUHS's unique objective of preparing graduates for a lifelong career in military medical service. So too, emphasis is placed on teamwork, particularly cooperation with nurses, ancillary staff, and medics. In addition, USUHS medical students must learn administrative subjects generally not taught in civilian schools, such as how medical care is organized and delivered in the civilian sector as well as in combat situations.

Human rights in the USUHS curriculum

At USUHS, second-year medical students are required to take an ethics course. The syllabus presents eight Prioritized Learning Objectives:

1. To consider whether military physicians during combat should attempt to save their own soldiers' lives by giving less than optimal treatment to captured enemy soldiers to elicit information from them.
2. To consider the extent of military physicians' obligations to enemy soldiers.
3. To consider military physicians' potential moral conflicts when providing care to civilian patients in occupied territory in part for political gain.
4. To consider military physicians' duty when servicepersons/patients give them confidential information.
5. To consider military physicians' duty to warn servicepersons/patients who come to them for treatment that they will report information these servicepersons disclose prior to servicepersons disclosing it.
6. To consider military physicians' duty when they treat soldiers during combat who want to return to combat or to be relieved from duty.
7. To consider ethical dilemmas which can arise in mass casualty situations when injured persons include one's own troops, enemy soldiers, and civilians.
8. To consider the extent of military physicians' ethical obligations to servicepersons and other beneficiaries of military medical care during peace.

There is no learning objective that directly refers to the role of military physicians in interrogation or in detention centers. However, the syllabus declares:

This session addresses ethical dilemmas in military medicine. New questions have emerged since 9/11. For example, what is permissible during interrogations of suspected terrorists? What are military physicians' moral obligations when they learn of or suspect severe harm or pain or even death?

The course's required reading, reviewed by the Task Force, contained seven works. The Task Force does not find the reading representative of the field. Of greater importance, the works are skewed toward instructing students in achieving military objectives or what is referred to as "balance" in situations where students should be instructed in the binding commitments the United States has made under Geneva Conventions and human rights treaties regarding the treatment of prisoners and civilians.⁸ One reading asserts that "war fundamentally transforms the major principles and central issues that engage bioethics" and that the "interests of the state and political community may outweigh consideration of patients' welfare."⁹ These statements conflict with accepted approaches to military medical ethics that recognize the primacy of human rights.¹⁰

The course's recommended readings consist of 64 works with wide range, some of which take a more traditional view of the primacy of the patient-physician relationship, making it clear that a physician as a professional owes primary loyalty to the patient or prisoner. However, it is unclear how much attention students give to these recommended materials. Additionally, some of the materials contain DoD guidance on medical care for detainees, such as psychological assessments for interrogation, that the Task Force criticizes elsewhere in this report.

In the USUHS ethics course, lectures on the seven required readings are followed by small discussion sections. Facilitators present case studies to their sections and the students are asked questions about how they would respond to a specific situation. Of 12 cases, some are hypothetical and some are based on actual events. All the cases are sophisticated. They address dual loyalties, conflict of interest, and human rights in ways civilian medical school bioethics courses do not. The facilitator's guidelines instruct section leaders to raise specific questions.

CASE 1

An Al Qaeda leader is being questioned by US interrogators. He has been shot in the groin and is in pain. You are asked to be present as the painkillers are used 'selectively' until he agrees to cooperate more fully.

(See recommended reading #22 [an article from the Washington Post, July 2003: "A Lone Woman Testifies to Iraq's Order of Terror"].)

What should you do?

Section leaders are to tell students that information gained using this method might lead to the capture of Al Qaeda leaders, and the students are then asked whether this would "warrant" the participation of military physicians in this practice. The facilitator is instructed to explain that "the traditional value has been that physicians should not [use pain killers selectively] whether in the military or not."

Although the facilitators are not asked to discuss the violation of the Hippocratic Oath, they are told to raise questions about when "doing harm" is justifiable. Students are to be asked to consider how certain they should be that a terrorist has such information and whether this information is relevant to the case. Students are further to be asked whether they believe physicians should participate in interrogations at all, and if so, within which limits. If the students argue that physicians should never participate in interrogation, the facilitator is instructed to raise questions concerning the obligation of physicians to act as whistleblowers for interrogations in which they suspect or believe acts of torture have occurred.

CASE 2

A captured enemy soldier is brought to you by members of your own troops who are specialists in interrogation. They tell you that this man knows vital information which could prevent an entire unit's being destroyed. 'It is absolutely necessary that he give this information.' The interrogators want you to give this soldier succinylcholine to transiently paralyze his respiratory muscles so that he will remain alert but unable to breathe to induce him to talk. (Note that the effect is similar to the sense of drowning by suffocation induced by the use of wet towels used in the interrogation of captured Al Qaeda leaders. ...

What do you do?

Assume you refuse. You are asked instead to give him intravenous sodium amytal (truth serum) to attempt to get him to talk by 'losing his inhibitions.' The drug will not cause pain, but will produce an effect similar to the moderate intoxication which occurs after one takes several drinks.

What do you do?

The facilitator's guidelines characterize this case as one that involves "military physicians being asked to treat enemy soldiers less than optimally for the purpose of saving their own soldiers' lives." The students are asked to consider the following: Is there a difference between asking the physician to inflict pain (administering the succinyl choline) and asking the physician to do something which does not inflict pain, but which is neither medically necessary nor therapeutic (administering "truth serum")?

In a third hypothetical case, the physician is asked to withhold pain medicine from an enemy combatant with a shoulder wound until he answers questions. In this hypothetical the physician is not being asked to participate in the actual interrogation, so withholding the medication is characterized as an "act of omission." However, the instructor's guide never discusses the role of a physician as facilitator of interrogations.

Case 5 concerns the case of Captain Howard Levy, an army doctor at Fort Jackson, South Carolina, who refused an order to train the Green Berets (U.S. Army Special Forces) to train medics on certain medical conditions on the grounds that they would exploit medical practices to commit war crimes in Vietnam. Levy argued that the order was illegal on the grounds that it was in violation of medical ethics. The facilitator's guidelines for the Levy case begins by clarifying the stakes: "The students, at a minimum, should be aware that if they use their medical skills in part for a political purpose, whether this is justifiable or not, ethically, they are exploiting these patients' vulnerability (due to illness) and, to some extent using these patients as means to others' ends (as opposed to treating these patients as ends to themselves)." The discussion then moves into an analysis in which it is pointed out that gaining patients' favor is an "indirect" byproduct of providing medical care and is thus not exploitation of an "inherently coercive situation," as was the case two of providing care on the condition that the patient give specific information.

There is no suggestion that this moral relativism might be questioned by the students. The facilitators are encouraged to ask those students who consider any degree of exploitation to be morally reprehensible, whether they think that physicians in private practice exploit patients' illness to earn a salary.

It is unclear from the syllabus and facilitator's guidelines how much time is spent on each case or how the cases are discussed—how much provocative and stimulating debate occurs, how different one section leader is from another, and what, if anything, is done to encourage minority views.

Residency training/graduate medical education

All graduates of USUHS enter residency training within the military medical center system and graduates of civilian medical schools may also do so. Residency in a military medical center offers the potential for professional mentorship and connections for fellowships and/or jobs post-residency that will count towards the civilian graduate's mandatory four years of service. Because the main objective of the military medical system is to care for military personnel and their dependents, residency slots can be found in many areas including obstetrics and gynecology, pediatrics, psychiatry, primary care, surgery, and ER/trauma. There are 10 major military medical centers, which have some or all of these programs. The two largest are the National Naval Medical Center in Washington, DC, and the San Antonio Military Medical Center (U.S. Army and Air Force).¹¹

The majority of military physicians on active duty receive their education at civilian medical schools, so they never participate in the USUHS ethics course described above. Physicians in residency training programs receive ethics teaching only when exposed to ethical issues within the context of patient care—when patients refuse medical treatment or require determination of mental capacity to make decisions, or when family members disagree about end-of-life care. Residency programs may also offer ethics teaching during weekly grand rounds, with guest speakers, but the overwhelming majority of grand rounds speakers address scientific medical or surgical developments rather than ethical issues in medicine. It is unlikely that physicians committed to military service through the Health Professions Scholarship Program will have heard any lectures during their residency training that address human rights issues in general or the problem of dual loyalties encountered in the military.

Each military service has its own rules and requirements for graduate medical education with little coordination among them. The U.S. Navy, for example, requires 40-50 percent of its physicians to deploy as a general medical officer before performing residency training, immediately following internship. Most of these physicians are employed on ships, whether sent to disaster zones (earthquakes, floods) or to serve as the shipboard physician. Once they have completed a year of service, they may then continue with residency training. The navy has contracts with civilian hospitals, and approximately 40 percent of its physicians do civilian residencies.

The U.S. Army, on the other hand, permits its physicians to complete residency training regardless of whether they are graduates of USUHS or of the health scholarship loan repayment program. A centralized medical education direc-

torate oversees the army's medical education programs, both undergraduate and graduate (GME), including all physicians from the Health Professions Scholarship Program, as well as those from USUHS.¹² An army physician who deploys immediately after residency earns "points," which enhance his or her chances of securing a limited slot in a fellowship or sub-specialty program. Physicians earn more points if they are deployed to a combat zone as opposed to a natural disaster zone. As a result, the physician who receives a competitive training slot may not be the most qualified in terms of merit, that is, excellence during residency judged by superiors while training and high board scores. An army physician may also deploy before completing residency training as a general medical officer. Thus, a physician who has completed only medical school and an internship, and therefore has the least amount of clinical experience and judgment, could well end up in combat.¹³ Despite repeated requests in writing, the Task Force has not had the opportunity to obtain any information on how frequently these least well-prepared medical professionals are sent into combat, or whether they receive enhanced or extended pre-deployment training.

Basic officer training

All military physicians must undergo basic officer training. Physicians attend this course either during residency or upon completion of medical training prior to assignment to the medical center where they have "matched." Each military medical center is required to regularly supply physicians in given specialties for deployment to combat areas, with specialty and destination dictated by military need. All military medical centers are part of a planned rotation for supplying physicians to combat areas. The rotation order is unknown to medical personnel at these centers in order to prevent physicians from gaming the system and requesting assignment to a particular center which recently deployed.¹⁴ Physicians receive the basic officer training course before commencing work in the military medical center, but some physicians may be deployed immediately thereafter if their center is next in the rotation or if there is demand for a certain specialty such as general surgeons or emergency physicians.

The basic officer training course provides orientation to the Army Medical Department and includes non-medical subjects. Physicians enrolled in the course purchase a copy of *The Army Officer's Guide*, a 450-page publication covering the history of the U.S. Army and its officers, their mission in and out of combat, leadership development, and role-modeling. All officers, physicians included, are taught the major sources of military criminal law and some con-

tent of the Uniform Code of Military Justice and the Manual for Courts-Martial. The content available for the Task Force's review pertains to criminal behavior against the U.S. Army and/or civilian personnel and property, not abuses of enemy captives. However, officers are required to learn the 1949 Geneva Convention on the wounded and sick, with specific attention to Field Manual 27-10, the Law of Land Warfare.

Army Field Manual 27-10, originally issued in 1956 and revised many times since, is a 180-page document that reviews the purpose of the laws of war and 12 treaties signed by the United States, including the four 1949 Geneva Conventions regarding the treatment of prisoners of war and the protection of civilians. The field manual contains a definition of a prisoner of war and what rights must be respected that is taken directly from Article 4 of the 1949 Third Geneva Convention.¹⁵ The manual quotes Article 17 of the third convention as well:

*No 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 whatsoever. Prisoners of war who refuse to answer may not be threatened, insulted or exposed to unpleasant or disadvantageous treatment of any kind.*¹⁶

The materials also explain that those captured who are not considered prisoners of war are "protected persons," as stipulated by the Fourth Geneva Convention. This includes "all persons who have engaged in hostile or belligerent conduct but who are not entitled to treatment as prisoners of war."¹⁷ The U.S. Army field manual also quotes directly from the Fourth Geneva Convention, which relates to the protection of civilians.¹⁸ If for security reasons, such protected persons are deemed a threat, they may be interned, but all such decisions about internment must adhere to the convention, follow regular formal procedures, provide legal counsel of the defendant's choice, and follow a timely appeals process schedule. These protected persons are entitled to medical attention, adequate food and hygiene, and the right to be visited by delegates of the International Committee of the Red Cross.¹⁹ Furthermore, coercion, corporal punishment, and torture are explicitly prohibited, again citing the Geneva Conventions directly, articles 31 and 32:

No physical or moral coercion shall be exercised against protected persons, in particular to obtain information from them or from third parties... [detaining power is] prohibited from taking any measure of such a character as to cause the physical suffering or extermination of protected persons in their hands. This prohibition applies not only to murder,

*torture, corporal punishment, mutilation and medical or scientific experiments... but also to any other measures of brutality whether applied by civilian or military agents.*²⁰

Officers are instructed on professionalism under the heading "Foundations of the Profession - Values and Ethics of Decision Making." The manual on leadership focuses on combat stress and leadership training, and covers "the warrior ethic," character development, and leadership competence, using such exhortatory language as:

*Doing the right thing is good. Doing the right thing for the right reason and with the right goal is better. People of character must possess the desire to act ethically in all situations. One of the Army leader's primary responsibilities is to maintain an ethical climate that supports the development of such character. When an organization's ethical climate nurtures ethical behavior, people will, over time, think, feel and act ethically. They will internalize the aspects of sound character.*²¹

Other DoD courses and pre-deployment guidance

According to the survey conducted by the Surgeon General, through early 2005 more than 90 percent of medical personnel (which included physicians, other health professionals, and enlisted personnel) in military detention facilities in Iraq and Afghanistan and at Guantánamo had received no formal or pre-deployment training in the generation, storage and collection, and disposition of detainee medical records.²² Similarly, very few medical personnel in Afghanistan and Iraq, and only half of medical personnel sent to Guantánamo, received either formal or pre-deployment training in reporting detainee abuse beyond general training in the Geneva Conventions, though some (still fewer than half) received training in theater in Iraq and Afghanistan).²³ Indeed, the Surgeon General found that in Afghanistan and Iraq, most medical personnel were unaware that they would be engaged with detainees before their deployment. Medical personnel reservists deployed in all three locations received even less training.²⁴

The Surgeon General also found that to the extent training was offered at all, the training materials on these subjects developed by the Army's Medical Department Center and School, which develops courses and trains medical per-

sonnel in all military services, was seriously deficient. His report found that lesson plans used for training were thin and unhelpful: their case examples were dominated by scenarios where abuse was readily apparent, and did not include case studies for role-playing regarding actual or suspected abuse. No pocket or quick-reference guides were available for students and deploying medical personnel to identify their responsibilities for reporting actual or suspected abuse.²⁵ Nor did lesson plans address medical screening for abuse, cultural considerations, language barriers, use and limitations of interpreters, concerns around interrogations, distinguishing between abuse and lawful combat operations, signing death certifications, emotional aspects of caring for detainees, and documentation. More subtle issues that present real-world ethical issues were not included.²⁶ Further, the Surgeon General found that the contents of training had not been vetted by military service members with appropriate knowledge of detainee care at points of capture, temporary detention areas, and detention facilities.

The Surgeon General made comprehensive recommendations for reform of training programs for medical personnel at all levels to prepare them for interactions with detainees, including case studies and scenarios that would enable and empower medical personnel to adhere to standards of care, comply with ethical obligations, and have a means to raise concerns where either practice or ethical standards are not followed. He also recommended that training assume that all medical personnel deployed would have interactions with detainees and to design training accordingly.²⁷

Finally, the Surgeon General recommended that the medical command provide senior medical officers with policies, regulations, rules, guidance, and tools that are accessible in theater and approved for continuing education credits. The tool it cited as an example was “A Health Professional’s Guide to Medical and Psychological Evaluation of Torture,” written in 2001 by Physician for Human Rights and based on the Istanbul Protocol.²⁸ The Assistant Secretary of Defense for Health Affairs responded to these recommendations by requiring that all military services ensure that “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.” He ordered that the program include basic training for all military health care personnel who may be deployed in support of military operations and whose duties may involve support of detainee operations or contact with detainees, refresher training, and additional training for health care personnel assigned to support detainee operations commensurate with their duties.²⁹

Some of these recommended reforms have been implemented, though the Task Force requested but was not able to access materials used for general or pre-

deployment training that cover the responsibilities of medical personnel toward detainees. The Task Force is aware of a course for non-commissioned officers, called “Medical Ethics and Detainee Operations.”³⁰ On the other hand, it is clear to the Task Force that not all recommendations of the Surgeon General have been followed, in part because the underlying ethical and human rights requirements for treatment of detainees remain inadequate. For example, to the Task Force’s knowledge, the Surgeon General’s specific recommendation to train medical personnel in examinations for torture based on “A Health Professional’s Guide to Medical and Psychological Evaluation of Torture” or other teaching tools for the Istanbul Protocol has not been followed. If that is the case, it is likely a product of the fact that the DoD does not require that clinicians engage in clinical examinations to determine if torture has taken place, only to report torture if they encounter evidence of it. In other words, it does not follow UN-sanctioned Istanbul Protocol methods in investigations (see chapter 2).

Nor is there likely to be any training in responding to hunger strikes in accordance with the requirements of the World Medical Association’s Declaration of Malta (see chapter 3) because the DoD does not adhere to its requirements. Nor, finally, is there training that recognizes the ethical problems inherent in health professional participation in interrogation via the Behavioral Science Consultation Teams (BSCTs) because the DoD declines to follow the ethical standards of medical organizations.

Thus, while the DoD is to be commended for taking steps to train medical personnel in ethics and practice obligations with respect to treatment of detainees, where it does not adhere to professional standards in such practice and ethics, training will remain deficient.

Training for behavioral science consultants

The U.S. Army, which is responsible for BSCT guidance, acknowledges that in the area of psychologist and forensic psychiatrist support for detention operations and interrogation, “there is little information and research published on this emerging area of practice,” that no certification process exists for work in the field, and that there is a danger that “[psychologists may be pushed forward on the battlefield, beyond readily accessible supervision or consultation.”³¹

This acknowledgement, combined with the severe ethical concerns raised by participation, should have led the DoD to refrain from using psychologists and forensic psychiatrists in interrogation at all. Instead, the U.S. Army has established a training program for BSCTs that covers a range of subjects arguably

related to interrogation, including learning theory, personality development, the psychology of influence and persuasion, psychological aspects of captivity, impact of counter-interrogation training, cultural issues, psychological dimensions of abuse, doctrine on interrogation, legal matters, and ethics (as interpreted elsewhere in the guidance).³² The guidance also urges BSCT members to consult with others. The Task Force does not believe this training can meet minimal standards for professional training because of the gap in evidence, thus rendering participation in interrogation all the more inappropriate ethically.

Health professional accountability for acts of torture through state licensing and discipline

NO HEALTH PROFESSIONALS WHO WERE EMPLOYED by or contracted with military and intelligence agencies have been held accountable for any acts of torture and other forms of mistreatment of post-9/11 detainees, either by those agencies or by civilian disciplinary boards. The costs of non-enforcement are great: non-enforcement undermines professional standards, erodes public trust, and undercuts deterrence of future misconduct. Lack of consistent enforcement also compromises protection of health professionals who face institutional pressure to violate their ethical obligations. By contrast, attention to accountability signals to licensees and those who employ them that the profession and institutions designed to ensure adherence to ethical obligations take violations seriously. Moreover, it empowers health professionals to resist demands by commanders to engage in acts that violate their professional responsibilities and to report abuse when they believe it has occurred.

Health professionals alleged to have been complicit in detainee abuse can be investigated, and if warranted, held accountable in several ways, including through disciplinary actions within the military, criminal prosecution within the military or through civilian courts (including international courts),¹ civil suits,² public censure (naming and shaming websites that post evidence of complicity, for example),³ and proceedings by state health professional boards. Extensive consideration of the last mechanism, the main subject of this chapter, is warranted because these boards, with few exceptions, are the sole civilian institutions charged with regulating the professions through the conferring of licenses and the enforcement of professional standards.⁴ Moreover, the military relies on state board licensing to ensure the quality of its health professionals; many of the military and intelligence health professionals who participated in detainee abuse, for example, did so while working in positions that required them to hold state licenses.⁵

In the interest of full disclosure, we note that the Task Force includes members who have been or continue to be involved as complainant (Dr. Steven Reisner) or counsel (Deborah Popowski) in some of the professional misconduct complaints and appeals discussed in this chapter. However, the Task Force does not take a position as to whether any of the individuals against whom complaints have been made are, as factual and legal matters, responsible for the conduct alleged in these complaints. Nevertheless, observations about these complaints, as well as historical antecedents in other jurisdictions, do inform our findings about the structural deficiencies in disciplinary standards and procedures where military or intelligence health professionals may have engaged in misconduct and our recommendations that flow from them.⁶

The failure of states to discipline health professionals who participated in or facilitated torture or cruel, inhuman, or degrading treatment

To date, state licensing and disciplinary boards in Alabama, California, Georgia, Louisiana, New York, Ohio, and Texas have received and then dismissed complaints against health professionals for alleged abuse of detainees at Guantanamo and secret CIA detention centers. To our knowledge, none of these complaints of complicity in abuse has led to a formal hearing on the merits, let alone any formal sanction,⁷ suggesting that the system of civilian discipline has not adequately addressed acts conducted during military or intelligence agency activities. The near-uniform dismissal of claims without substantive investigation into the merits suggests further that disciplinary boards are effectively exempting licensees who work for national security agencies from the standards these boards are meant to enforce. Additionally, the dismissal of complaints may signal to military and intelligence health professionals that the tolerated and safer course of action is to participate or silently acquiesce in abuse.

In almost all cases the boards either did not explain the reason for dismissal or did so in such cryptic terms, such as claiming lack of jurisdiction without specific explanation, that the basis for the decision remains opaque. All but one failed to address the evidence submitted by the complainant. Nor did any board provide grounds to believe that the individual's conduct conformed to professional standards.

We on the Task Force are not privy to the thinking of the boards. At most, we can propose factors that may have contributed to the consistent pattern of dismissal. A state licensing board might have considered the professional's conduct

to be outside its jurisdiction because it occurred out of state, was under the auspices of the federal government, or involved national security policy or practice. Or it might have decided that the complaint was not filed in a timely manner under a governing statute of limitations. Decisions to dismiss might involve the substance of the complaint, such as a belief that the conduct did not constitute the practice of medicine or psychology, that the licensee owed no duty of care to the prisoners allegedly harmed, or that the complaint was frivolous and not worthy of investigation. Evidentiary concerns as well might animate the decisions, such as a concern that an investigation might not yield sufficient evidence to bring charges, or that barriers, in access or cost, to obtaining evidence are likely to arise. Concerns about coordination and cooperation with the federal government may also be at play. A board might consider an investigation and prosecution possible, but not the best use of its resources, because, for example, it might not have deemed the health professional to pose a current threat to public safety in its state because the professional does not currently practice in the state, is not likely to repeat the conduct, or the board considers the alleged victims unworthy of protection because they do not reside in the state, are not U.S. citizens, or are suspected of terrorism.

A board could also be guided by its members' moral or political beliefs on torture or national security. For example, board members or staff might conclude that the alleged conduct was technically improper, but not morally objectionable given the supposed need to fight terrorism. They might believe that by participating in interrogation of detainees, the health professionals were seeking to minimize harm to the board and other members of the public. They might conclude that health professionals should not be sanctioned for following government policy or military orders, or for engaging in conduct deemed by their superiors to be legal and warranted. A board might also respond to political forces hostile to accountability or conclude that the public believes the health professionals were keeping the nation safe and, based on this, would not support or want them professionally sanctioned.

Finally, a board might be driven by self-protection and the desire to avoid the potential controversy that might result from taking disciplinary action or closing off opportunities for health professionals in the national security realm. The board might fear that doing otherwise would provoke discord within the profession that could lead to public distrust and/or hinder individual members or staff's own professional advancement.

Ascertaining whether these or other reasons motivated the boards' dismissal of complaints is beyond the scope of this report. The appendix outlines summaries of what is publicly known about the handling of the complaints by

boards. It reveals both process and substantive deficiencies that warrant reform in the way state boards approach discipline of health professionals who are alleged to have been complicit in torture or other forms of prisoner abuse. If unaddressed, the structural features that permitted dismissal of complaints will continue to allow perpetrators of severe harm on detainees to avoid professional consequences, which in turn will have a long-term, detrimental impact on public trust in the health professions and the boards that regulate them.⁸ We propose substantive and procedural reforms relating to discipline of health professionals for acts of torture or other forms of prisoner abuse,⁹ as well as changes to federal law to improve the capacity of state licensing boards to address misconduct allegations against health professionals working in military and intelligence settings.

The deficiencies in the state boards' response to complaints of health professional involvement in abuse of detainees, and remedies for those deficiencies, include:

1. Lack of specificity on whether the health professional abuse of detainees constitutes misconduct under the law. Some of the state boards stated, without explanation, that no violation of state standards of conduct had occurred, raising the question of whether the standards they employed were sufficient to judge serious allegations of detainee abuse. Although general definitions of misconduct should encompass these acts, prospects of accountability would improve if state laws specifically addressed the full spectrum of the problem. They should draw from domestic and international standards about conduct of health professionals in connection with prisoners and clearly and broadly prohibit any form of complicity or participation by health professionals in torture and other forms of prisoner abuse.
2. Lack of specificity of particular forms of conduct such as involvement in and advising on interrogations and conditions of confinement. As with respect to coverage of detainee abuse generally, current law on misconduct should embrace these acts, but given boards' (in the Task Force's view, mistakenly) narrow construction of the law, setting forth the kinds of acts covered would advance accountability. In one case, a state board asserted that if the alleged acts took place, they would fall outside the definition of the practice of psychology, which it interpreted as encompassing only beneficent actions. State laws, drawing from domestic and international standards, should clearly and broadly prevent health professional involvement in programs or policies that include these acts.

3. Inadequate standards regarding discipline for failure to report abuse. State laws should include a duty to report prisoner abuse, while providing whistleblower protections for those who do report it and reinforcing health professionals' obligation to protect the confidentiality of prisoners' medical information.
4. Lack of specificity on jurisdiction to investigate and prosecute without exceptions as to location, time, or other circumstance. A number of state disciplinary board decisions claimed lack of jurisdiction, so state legislatures should explicitly state that such jurisdiction exists.
5. Overbroad claims by boards of discretion to refuse to investigate. Most state boards did not conduct investigations of the allegations, and some courts have thus far upheld their authority to decline to open an investigation without possibility of judicial review of that decision. While boards need to have some discretion in handling complaints, they should not be permitted to dismiss complaints that make legitimate claims of misconduct, nor to refrain from explaining the basis for the case. State laws should make clear that: (1) state disciplinary boards have both a mandatory duty to investigate non-frivolous complaints of health professional involvement in torture or other forms of prisoner abuse and a prima facie duty to charge the licensee in cases in which it finds probable cause of such misconduct, and (2) that compliance with these duties be verifiable through transparent public proceedings that (a) safeguard confidentiality and (b) rest upon the authority to subpoena documents, compel witnesses, and take other steps necessary to ensure full inquiries that comport with due process.
6. Claims of lack of availability for judicial review. Courts have thus far declined to review the decisions of state boards to determine whether boards abused their discretion or acted arbitrarily. State laws should ensure opportunities for meaningful judicial review by all complainants of disciplinary board decisions in cases involving torture and other forms of prisoner abuse, irrespective of the stage at which a board decision is reached.
7. Inadequate resources to investigate and prosecute. Given the centrality of state disciplinary processes to ensure the proper conduct and fitness to practice of health professionals, state and federal law should guarantee disciplinary boards the resources, training, and access to

expertise necessary to handle cases involving prisoner abuse and health professional conduct in military and/or intelligence settings.

8. Uncertain commitments of cooperation from the federal government. Military and intelligence agencies should commit to cooperate with state disciplinary boards with respect to conduct of health professionals while in federal service. Federal law should require federal agencies to cooperate fully with any state disciplinary board proceedings involving health professionals in federal roles, including making evidence available. It should reinforce the authority of state disciplinary boards to conduct such investigations and to provide whistleblower protections for persons making such referrals.

We recognize that correcting these deficiencies is politically difficult. A historical and comparative look at societies that have dealt with systematic torture suggests that it often takes years, as well as persistent effort from civil society, for institutions to hold state agents accountable for violations committed as part of government-sponsored policy during a time of conflict.¹⁰ State boards have been operating in a political climate where accountability of officials responsible for developing and implementing policies of torture of detainees has been absent, and the boards have been acting much like the federal courts and political branches in resisting accountability. The fact that other institutions, including the U.S. Department of Justice, Congress, the military, and the federal courts, have showed little appetite for pursuing accountability for these abuses has contributed to a climate that offers state disciplinary boards little to no institutional pressure or incentive to prosecute cases tied to practices carried out in the guise of national security. Nevertheless, there is precedent in Argentina, Chile, Brazil, South Africa, and Uruguay for authorities with responsibility for medical licensing or discipline to take action against health professionals who engage in torture. Actions in those countries can inspire reform in the United States.¹¹

Necessary reforms

DISCIPLINE OF HEALTH PROFESSIONALS

ALLEGED TO HAVE ABUSED PRISONERS OR DETAINEES

Health professionals in the United States are regulated by state licensing and disciplinary boards created by state statutes.¹² These boards exist for a range of health professional disciplines, and although their regulatory structure and authority

vary by state,¹³ they share a stated purpose to protect the public from the unsafe or unauthorized practice of members of the health professions.¹⁴ They generally have two principal responsibilities: to control the procedure by which new health professionals are admitted to practice in the state and to enforce standards of professional conduct.¹⁵ Boards issue licenses to professionals who meet those standards and investigate and discipline those who fail to meet them.¹⁶

In their disciplinary function, professional boards investigate complaints against practitioners that claim their incompetence and unprofessional or unethical conduct.¹⁷ While substantive grounds for discipline are state-specific, most jurisdictions discipline gross incompetence, alcohol or drug abuse, unlicensed practice, or other conduct that violates certain ethical standards or brings the profession into disrepute.¹⁸ Boards also issue sanctions, which can range from a reprimand to the suspension or revocation of a license to practice in the state.¹⁹

State disciplinary boards have an important relationship with private professional medical associations. Both state and national health professional associations play an influential role in shaping state legislation and regulations affecting their professions. As noted in the chapter on professional associations, these groups create professional norms through their ethical codes and opinions and influence the content of legislation or regulations affecting the profession.²⁰ Some states incorporate ethics codes promulgated by national associations like the American Medical Association and the American Psychological Association²¹ into their laws and rules or look to them for guidance in interpreting their own standards.²²

Ideally, professional associations and state boards would work together to use their complementary powers and functions to ensure that health professionals alleged to have been involved in torture and other forms of prisoner abuse are appropriately investigated and, if warranted, disciplined. As set forth in chapter 5, however, health professional associations in the United States have not been proactive in the effort to investigate doctors, psychologists, and others involved in this type of conduct.²³ Instead, the associations have avoided both general reviews of the roles of health professionals in detainee abuse, and, to our knowledge, investigations of misconduct of their members. While some associations have taken the position that discipline is exclusively within the purview of the boards,²⁴ they have, with one notable exception,²⁵ done little to support or encourage the investigation of complaints. The apparent indifference and in some instances resistance of professional associations to such investigations may be rendering boards less likely to investigate or sanction military and intelligence health professionals for alleged prisoner abuse, especially if doing so might be perceived as going against the views of professions.

Critics argue that state health professional boards have too close a relationship with the guild interests of professional associations, furthering professional self-interests and creating barriers to entry into the profession, rather than furthering the public interest.²⁶ We as a Task Force take no position on this question but note that legislatures, and the boards they establish, do have responsibilities to ensure that health professionals they license behave in accordance with expectations of society for ethical practice.

REGULATION OF HEALTH PROFESSIONALS IN CONNECTION WITH PRISONER AND DETAINEE ABUSE

We propose enactment or amendment of state legislation that governs professional disciplinary mechanisms. The Task Force is of the view that legislation, in addition to any changes initiated by the state boards themselves, is necessary because of the importance of changing the legal norms, the long-term instability of mere regulatory changes, and the expressive value of the law. Other mechanisms for improving discipline for these offenses are available,²⁷ especially changes at the federal level to strengthen the effectiveness of the state disciplinary process in connection with the conduct of health professionals in federal service.²⁸ Achieving any of these changes will require significant outreach, education, and engagement of both health professionals and the general citizenry. State regulatory boards implementing such reforms will also need additional resources, support, and access to expertise to allow them to adequately implement the tasks set out to them.

Although there is some commonality among state disciplinary boards on the type of conduct that constitutes grounds for disciplinary action²⁹ as well as in procedures for handling complaints, scholars, advocates, and policymakers nevertheless face more than 50 sets of state standards and regulatory frameworks that vary in structure, authority, and process.³⁰ Mindful that each state would need to engage in its own process of legal reform, we identify elements we consider essential to addressing health professional participation or complicity in the torture or cruel, inhuman, or degrading treatment of prisoners. The Task Force proposes that key stakeholders and leadership organizations, including the Institute of Medicine, professional associations, and human rights groups, draft a model law following the recommendations we make to facilitate writing legislation at the state level and to encourage uniformity in ensuring effective regulation of the professions regarding prisoner abuse.³¹ In the first state-level initiatives to address the problem, pending legislation in New York and Massachusetts already incorporate some of the recommendations we make and could be instructive for the drafters of the model law.³²

Although we call for enactment of legislation, in some cases changes could be made administratively by the state boards themselves. To the extent changes can be made at the administrative level, model board policies could be created by the National Federation of State Medical Boards in consultation with professional associations and human rights groups.

CLARIFYING AND EXPANDING THE DEFINITION OF PROFESSIONAL MISCONDUCT TO EXPLICITLY ADDRESS INTERROGATION AND TORTURE OR CRUEL, INHUMAN, OR DEGRADING TREATMENT

Many states' professional misconduct laws and regulations include catch-all provisions that would reasonably be read as encompassing many forms of complicity by health professionals in prisoner abuse. Nevertheless, given the apparent views—which the Task Force believes are inconsistent with law—among at least some state boards that participation in torture or cruel, inhuman, or degrading treatment of detainees does not amount to professional misconduct, we recommend that states amend their laws to prohibit explicitly the participation of health professionals in interrogations and torture or cruel, inhuman, or degrading treatment. Such amendments would have the following goals: (1) to ensure that using professional knowledge and skills to intentionally cause prisoners serious harm is cause for sanction, regardless of the identity of the victim or the location and context in which it occurs; (2) to signal clearly to boards the expectation that they discipline health professionals who engage in this behavior; and (3) to remind health professionals about their ethical obligations in settings where there is extraordinary pressure to subordinate the interests of the patient or detainee to the stated interests of the employing institution.

State legislation addressing health professional participation and complicity in torture and other forms of cruel, inhuman, or degrading treatment should incorporate relevant professional and legal norms

In addition to referring to existing state norms against abuse, legislation should incorporate existing professional standards relating to the treatment of prisoners and specifically forbid the participation and complicity of health professionals in torture and other forms of abuse.³³ It should also reference U.S. law, including federal anti-torture statutes and the prohibition on cruel or unusual punishment under the Constitution, and international standards, including those promulgated by the United Nations, the World Medical Association, and the International Covenant on Civil and Political Rights, and the Convention Against Torture, the Geneva Conventions, and other treaties the United States has ratified regarding

torture or cruel, inhuman, and degrading treatment. Referring to international professional and legal norms in addition to state and federal ones ensures that health professionals receive guidance on compliance with human rights norms and avoidance of liability not only before disciplinary boards, but also foreign and international criminal courts that have jurisdiction over acts of torture. Such legislation would also provide greater insulation from manipulation of both the definition of torture and the scope of ethical responsibilities such as has taken place in the United States in the post-9/11 period.³⁴

State legislation should ensure that the prohibition on participation or complicity in torture and other forms of cruel, inhuman, or degrading treatment applies whenever licensed health professionals use their specialized knowledge or skills

In a case presenting evidence from official reports and declassified documents in support of allegations that a psychologist was directly involved in the torture of a detainee at Guantánamo, the New York Office of Professional Discipline, which oversees discipline of New York-licensed psychologists, decided that no violation of state law on professional misconduct had been alleged. It argued that the acts identified were inconsistent with the beneficent purposes of psychology and that a therapist-patient relationship had not existed. As a result, it concluded that the individual, while licensed and using specialized skills, was not engaged in “practice of psychology because the actions were not desired by the detainee to whom they were applied.”³⁵

The circular reasoning of the board, which defines acts of abuse as not within the practice of psychology, is inconsistent with other provisions of law relating to misconduct, such as entering into a sexual relationship with a client, and with the very purposes of licensing. To prevent states from adopting the mistaken conclusion of the New York board that participation in torture of a detainee could not constitute the practice of psychology,³⁶ legislation should provide that torture or other abuse of a prisoner are forms of misconduct regardless of a provider-patient relationship or whether or not it involves attempts at diagnosis, treatment, or cure of any ailment.³⁷

State legislation should expressly prohibit a broad range of participation and complicity by licensed health professionals in torture and other forms of cruel, inhuman, or degrading treatment

Because the role played by a health professional in a system of torture and cruel, inhuman, or degrading treatment is often one of enabler or facilitator rather

than direct perpetrator, legislation should explicitly prohibit all forms of cooperation or complicity in abuse, not just direct action against a prisoner. Legislation should specifically prohibit health professionals from allowing their expertise to be used to facilitate torture or cruel, inhuman, or degrading treatment. This includes monitoring the infliction of torture or interrogation³⁸ or providing evaluations or treatment so that abuse can begin or continue (both prohibited under American Medical Association standards), and covering up or omitting signs of abuse in prisoner clinical records or other reports.³⁹

State legislation should prohibit licensed health professionals from participating in interrogations

As explained earlier in this report, all interrogations, even those conducted lawfully without the use of torture or cruel, inhuman, or degrading treatment, are inherently coercive.⁴⁰ As such, almost all professional organizations have opined that professionals who have been licensed for the purposes of providing care and improving health and well-being should not participate in interrogation, with participation defined to include evaluation of individual detainees to ascertain vulnerabilities, monitoring interrogations, advising interrogators before or during interrogation, or providing medical or psychological services so interrogation can continue. The ban on interrogation is also necessary as a prophylactic to prevent health professionals from being asked to calibrate pain, distress, or mistreatment, or exploit vulnerabilities, even in lawful methods of questioning.⁴¹

The prohibition on participating in interrogations, even lawful ones, is based on two main principles. First, health professional licenses are issued primarily for healing purposes,⁴² so when licensees use their specialized training and skill to inflict or calibrate stress without a healing purpose, they not only violate their duty to use their license beneficently, but undermine the value of the state license as a credential that connotes trustworthiness. Second, as noted above, the mere presence of a health professional in an interrogation can lend undue legitimacy to the methods used. This legitimacy can lead to increased use of force⁴³ or to support legal claims that the interrogation is not abusive.

State legislation prohibiting health professional complicity in torture and other forms of cruel, inhuman, or degrading treatment should define “prisoner” broadly

State professional misconduct legislation should define prisoner so that it includes individuals subject to interrogation or who are being deprived of their

personal freedom for national security, military, law enforcement, or immigration purposes.⁴⁴ A broad definition of prisoner based on the deprivation of one's personal freedom rather than technical legal categories (prisoner of war, pretrial detainee, etc.) allows health professionals to identify when their actions are subject to regulation without having to make determinations of status under legal categories.

State legislation should prohibit licensed health professionals from using their expertise to create or advise on conditions of confinement that impair the well-being of the prisoner⁴⁵

Such a prohibition would cover acts intended to disrupt or destabilize prisoners, to render them more susceptible to interrogation, or to diminish their ability to advocate for themselves. Examples include consulting on practices such as food or sleep deprivation, isolation, sensory deprivation, sensory overstimulation, and exploitation of religious beliefs and cultural mores that could negatively affect the well-being of a prisoner.⁴⁶

State legislation should reinforce health professionals' obligation to protect the confidentiality of a prisoner's medical information

Confidentiality of medical information is one of the cornerstones of health care. The American Medical Association's Code of Medical Ethics treats information gathered during treatment as confidential "to the utmost degree"⁴⁷ and sees the duty to maintain confidentiality as essential to providing appropriate care. Such confidentiality encourages an individual to seek out care when necessary, to trust providers, and to provide full information to the health professional. Health professionals working with prisoners also have a general duty to maintain confidentiality.⁴⁸ As noted in chapter 1, the consequences of breaching confidentiality at Guantánamo, especially to use medical information for interrogation purposes, compromised medical care for detainees and undermined their trust in clinicians.

U.S. law provides a broad exception to confidentiality of medical records for military, intelligence, or law enforcement purposes,⁴⁹ but adhering to such broad exceptions in the national security context undermines trust and the ability to provide sound patient care, and state legislation should reinforce confidentiality of prisoner medical information in connection with interrogation and discipline of prisoners as the rule rather than the exception.⁵⁰ Even exceptions in other circumstances should be rare, based on an important countervailing public need and tailored as narrowly as possible to that particular need.⁵¹

Whenever health professionals cannot guarantee the confidentiality of prisoners' medical information, the law should require that they clearly disclose the limits of confidentiality.

State legislation should require health professionals to report all incidents of suspected abuse of prisoners to the appropriate authorities in keeping with established ethical standards

As explained in chapter 2, health professionals' specialized knowledge and privileged access to prisoners render them particularly well-positioned to recognize the physical and psychological signs of torture and cruel, inhuman, or degrading treatment. As such, they can and should serve as a line of defense against these violations.⁵² When a health professional receives information indicating that torture or cruel, inhuman, or degrading treatment may have occurred or is occurring, the law should require the health professional to report the suspected abuse to a government agency that has the authority to, in the words of a proposed New York Assembly bill, "punish or prevent the continuation of torture or the [abusive] treatment of a prisoner.. .and is reasonably likely to do so."⁵³ The legislation should state that a health professional's duty to report is not discharged until a report is made to an authority that the professional reasonably believes will act to investigate and stop the torture or cruel, inhuman, or degrading treatment. Reporting to the same authority that is perpetrating the abuse will not suffice. To encourage the filing of complaints involving professional misconduct, most state boards have already promulgated a compulsory duty to report all violations.⁵⁴ This duty to report becomes even more important in cases involving military or intelligence detention, considering that most incidents of prisoner abuse in these settings occur in secret and the victims may be incapable of reporting the abuse themselves. Imposing such a duty, moreover, is consistent with the duty of members of the U.S. armed forces to report abuse.

State legislation should provide legal protection from reprisal to those who provide good faith reports of torture or other forms of cruel, inhuman, or degrading treatment to state disciplinary boards

Whistleblower protection for those who report torture and cruel, inhuman, or degrading treatment must go hand-in-hand with the duty to report. Although federal authorities are best placed to protect military and intelligence health professionals from retaliation, state legislatures can play a role by providing immunities, indemnities, and confidentiality to those who report related misconduct to boards.

CLARIFYING AND REINFORCING

THE PROCEDURAL DUTIES OF STATE DISCIPLINARY BOARDS

The primary mechanism used by state boards to discipline their licensees is the investigation and prosecution of professional misconduct complaints.⁵⁵ Although methods of processing complaints vary across jurisdictions and health professions, they generally include six stages: intake, investigation, charges, prosecution or voluntary settlement, hearing, and disciplinary action.⁵⁶ No other body is vested with this particular disciplinary authority.

The experience in the seven states in which complaints have been brought to date indicates the need to make even more explicit the boards' legal duties. Statutes governing disciplinary mechanisms would benefit from more specific language on jurisdiction and standards regarding legal duties to investigate, obtaining evidence, transparency in process and reasons for decisions, and provisions for judicial review. Vague articulation of these duties may be facilitating the dismissal of complaints alleging torture or other forms of cruel, inhuman, or degrading treatment. Such dismissals in turn may endanger the public by allowing health professionals who engage in prisoner abuse to continue to practice and by signaling to the profession that torture or prisoner abuse will be tolerated. Failure to respond adequately to evidence of torture also jeopardizes the integrity of professional standards and undermines their power to protect military and intelligence health professionals struggling to resist unlawful orders.

The Task Force recognizes that many of the proposals in this section could improve the boards' handling of complaints of professional misconduct beyond prisoner abuse.⁵⁷ We do not take a position, however, on applying these procedural recommendations in cases of other forms of misconduct, where different considerations may apply.

State legislation should make clear that disciplinary boards have jurisdiction to investigate and prosecute licensees for alleged involvement in torture or other forms of cruel, inhuman, or degrading treatment, regardless of the location, timing, or circumstances of the conduct

As discussed above, some state disciplinary boards have dismissed complaints against health professionals on the claim that the boards lacked jurisdiction over the conduct,⁵⁸ either because the alleged conduct occurred outside the state and/or in the context of military service⁵⁹ or because using professional skills to harm others did not constitute the practice of psychology.⁶⁰ State law should be revised to make clear that disciplinary boards have jurisdiction over health care personnel who are complicit in out-of-state occurrences of abuse,

including those that take place in the service of the military or another government agency, and conduct where professional skills are employed. The exercise of jurisdiction over military practice is consistent with congressional and Department of Defense (DoD) requirements that military health professionals hold a state license to obtain credentials and for reciprocal reporting of disciplinary action through national databases.⁶¹ Furthermore, the military expressly relies on the "issuing authority," usually a state, to regulate the quality and competence of the health professionals they employ.⁶²

State law should clarify that boards have a mandatory duty to investigate non-frivolous complaints of health professional involvement in prisoner abuse

Disciplinary boards traditionally have some discretion in determining whether to investigate a complaint of alleged violations of professional standards. However, the experience in the seven states shows that this discretion can be exercised far too broadly, by summarily dismissing complaints alleging serious violations of professional standards of conduct involving detainees, without any meaningful investigation into their merits. In doing so, the boards fail to fulfill their duty to protect the public in two important ways. First, they leave open the possibility that a health professional responsible for past serious harm will harm others in his or her continued practice. Second, they undermine the integrity of the disciplinary system and diminish the value of the credentialing process as an assurance to the public of a license as a sign of fitness to practice.

State legislatures can ensure that disciplinary boards fulfill their duties to protect by making explicit a mandatory duty to conduct reasonable and good-faith investigations of credible and non-frivolous allegations of serious abuse by health professionals, as they do in other types of serious harm to other vulnerable people.⁶³

State law should make clear that when boards find probable cause of participation or complicity in torture or other forms of cruel, inhuman, or degrading treatment, they have a prima facie duty to charge the licensee

Once the investigation phase is complete, state disciplinary boards can drop the case, issue an informal sanction (such as a letter or warning), or bring formal charges.⁶⁴ Just as with initial response to complaints, state disciplinary boards generally enjoy considerable discretion in deciding whether to charge a licensee—discretion that, in the absence of enforced boundaries, is vulnerable to abuse by boards faced with complaints regarding their licensees.⁶⁵ While preserving some degree of discretion is important to an efficient and effective dis-

ciplinary process, we believe safeguards are needed to ensure that boards do not dismiss cases involving allegations of serious prisoner abuse where a certain evidence threshold for bringing charges has been met. Such safeguards can counter potentially strong external pressure on boards to dismiss cases that involve licensees and prisoners in the national security context.

The Task Force therefore proposes that if state disciplinary boards receive enough evidence to support a finding of probable cause, the law should create a presumptive requirement to bring formal charges against the licensee. By making prosecution a prima facie duty applicable only to non-frivolous complaints, legislatures would ensure that disciplinary boards retain an important amount of discretion and do not waste resources on non-meritorious complaints.

Boards should be required by state law to articulate specific reasons for dismissal of a complaint alleging torture or other forms of cruel, inhuman, or degrading treatment and to inform the complainant of the nature and scope of its investigation

Most boards that have dismissed complaints against health professionals for torture or cruel, inhuman, or degrading treatment of detainees have provided only vague statements, if any, of the reasons for the decision. They also failed to inform the complainant of the steps the board took, if any, to investigate the complaint.⁶⁶ At least one board has asserted that it has no obligation to specify its reasons for dismissal.⁶⁷

Specifically requiring a board to state its reasons for dismissal would reinforce the duties to conduct reasonable and good-faith investigations and to formally charge licensees when probable cause exists of involvement in torture or other forms of prisoner abuse. Articulating these specific reasons is not a burdensome task.⁶⁸ The statement could be crafted so that boards can protect the privacy of the health professional against whom charges are brought as well as the patient(s), victim(s), and complainant where appropriate and necessary. When complainants have waived confidentiality or made their complaints public, the boards cannot legitimately consider confidential the mere existence of the complaint and investigation.

Consistent with the mandatory duty to investigate reasonably and in good faith, the law should require boards to inform complainants of the steps taken in their investigation, if any, as part of its decision to dismiss the complaint. This requirement would signal to the public that state boards take torture allegations seriously and are committed to upholding their mission of public protection. It would therefore enhance public trust in the disciplinary system.

State law should create a presumption that complaints of torture or other forms of cruel, inhuman, or degrading treatment be prosecuted formally by boards in hearings that afford the complainant opportunity to testify and call witnesses

Some jurisdictions afford disciplinary boards a choice of attempting to resolve the case informally or proceeding directly to a formal hearing.⁶⁹ Informal resolution usually involves a form of voluntary settlement.⁷⁰ Licensing boards may favor informal resolution because it allows them to dispose of matters without the time and cost of full hearings and eliminates the risk of losing the case. Health professionals who opt for informal resolution may do so to avoid the ordeal of a public hearing or the risk of a severe and public sanction.

In view of the existing record, informal disposition is not appropriate for complaints alleging torture by military or intelligence health professionals. As noted earlier, unlike usual cases of misconduct, the boards may face (or perceive) institutional or external political pressure to dismiss these cases. Informal, closed-door proceedings between the board and the licensee deny the public an opportunity to ensure the integrity of institutions such as military and intelligence agencies in which it has a tremendous interest. Accordingly, if a board has enough evidence to charge a licensee with misconduct relating to torture or other forms of cruel, inhuman, or degrading treatment, the presumption should be toward holding a hearing rather than informal resolution.

Once a licensee is charged with misconduct, it is not uncommon for the formal hearing to be public. Given that government-sanctioned torture is a matter of great public concern, hearings on cases involving torture or cruel, inhuman, or degrading treatment of detainees should be no exception. These can be supplemented with in-camera procedures, which should be developed to deal with classified information.

State law should guarantee that complainants have standing and a right of action to seek judicial review of a decision to dismiss a complaint involving torture or cruel, inhuman, or degrading treatment of detainees for abuse of discretion and error of law

Judicial review of decisions of regulatory agencies and boards is traditionally a means to ensure that they adhere to legal requirements and employ discretion appropriately, yet it has thus far been denied in cases dismissing complaints alleging torture by military and intelligence health professionals. To date, complainants have challenged dismissals by five state licensing boards.⁷¹ Thus far,

courts in Louisiana, New York, and Texas have ruled that these board dismissals were not subject to judicial review on the grounds that complainants' injuries were insufficiently concrete or direct to grant them standing to petition for review.⁷² These issues are still being litigated in Ohio.

As individuals and groups who work in the fields of psychology, juvenile justice, and gender and health justice⁷³ have explained, denial of review leaves professional boards with unchecked power to act arbitrarily or on the basis of erroneous legal determinations. They result in the absence of oversight of arbitrary, capricious, or erroneous board action that undermines state policy. Lack of judicial review also reinforces the external, structural incentives to avoid adjudicating such complaints. Given the relatively small number of complaints that have been filed (or are likely to be filed), their distribution across multiple states, and other reforms in board practice that would decrease the number of appeals, judicial review would not place an unreasonable burden on the judiciary.

States should eliminate time bars for misconduct complaints against health professionals alleging torture or other forms of cruel, inhuman, or degrading treatment

One state board cited a statutory time bar as its reason for not investigating allegations that a licensee had been involved in the torture of detainees.⁷⁴ Given the seriousness of the misconduct at issue and the need to protect the public in the future, state disciplinary boards should have the power to investigate related allegations regardless of when the conduct occurred.⁷⁵ Some states already refrain from imposing statutory time bars for all professional misconduct complaints⁷⁶ and some others make exceptions for allegations of serious misconduct.⁷⁷ Courts in the United States generally hold that, absent a statute of limitations applying specifically to proceedings to revoke a medical license, such proceedings should not be time-barred.⁷⁸

Eliminating statutes of limitations for cases involving torture or other forms of cruel, inhuman, or degrading treatment would also align with other areas of law in which statutory time bars are disfavored for exceptionally heinous conduct that poses serious threats to public safety.⁷⁹ Additionally, this step is consistent with other approaches to statutes of limitations where it is difficult to discover the facts, in this case exacerbated by policies that health professionals not reveal their names to detainees.⁸⁰ Further, because people working within the facilities rarely report abuse, it can take years before the information reaches a person able and willing to file a complaint.⁸¹

State law should ensure that disciplinary boards have the authority to subpoena evidence and compel witnesses in cases involving health professionals allegedly involved in torture or other forms of cruel, inhuman, or degrading treatment; federal agencies should cooperate and Congress should support this power

One state board concluded that the evidence presented by the complainant was insufficient for it to take disciplinary action.⁸² To our knowledge, the board did not interview witnesses or seek to obtain relevant documents from witnesses or the federal agency involved. Some boards already have the power to issue and enforce subpoenas for documents, people, and institutions,⁸³ and the Federation of State Medical Boards recommends granting such authority in its model medical practice act.⁸⁴ More robust investigative authority should provide boards with a more substantial body of evidence on which to base their disciplinary decisions. Given the DoD's reliance on state boards to ensure that its health professionals are licensed, it should cooperate in responding to requests for evidence. Consistent with its commitment to state licensing of all military health professionals, Congress can facilitate this process by ensuring that federal agencies comply with subpoenas in these cases. State legislatures can work with state boards, Congress, and relevant federal agencies to develop in-camera procedures to deal with classified information.

SUPPORTING STATE BOARDS IN ADDRESSING CHARGES OF TORTURE OR OTHER FORMS OF CRUEL, INHUMAN, OR DEGRADING TREATMENT AND PROTECTING INDIVIDUALS FILING COMPLAINTS

State legislatures should provide for training resources to board members and staff on how to handle complaints of misconduct in detention settings

State boards may need additional guidance for how to deal with cases involving torture or other forms of cruel, inhuman, or degrading treatment. The Federation of State Medical Boards can draft guidance in the form of a "bench book" to guide disciplinary board members and staff through the legal and ethical issues involved in investigating, prosecuting, and adjudicating health professionals accused of misconduct in detention and interrogation settings.⁸⁵ The bench book could be modeled after bench books created for other legal contexts to apprise judges of procedural rules and substantive issues, including professional codes.⁸⁶ It should be supplemented with a training program that would provide an opportunity for professional organizations and other experts to engage directly with those involved in health professional conduct adjudication.

Training materials should be made available to the public.

Both state legislatures and the U.S. Congress should ensure that state disciplinary boards receive funding to fulfill their mandate of regulating licensed health professionals serving in military and intelligence agencies

State disciplinary boards are notoriously under-resourced. In 2006, the U.S. Department of Health and Human Services identified “high costs and limited financial and human resources” as some of the “major obstacles to effective disciplinary enforcement by medical boards.”⁸⁷ Another study found that “larger medical boards and boards with more staff discipline doctors more frequently.”⁸⁸ Costs lead boards to prioritize cases that are easier to investigate, such as those involving licensees with existing criminal convictions,⁸⁹ and there are some suggestions that resource considerations may have influenced decisions in the cases discussed here.⁹⁰ Conversely, additional resources might increase the likelihood that boards will discipline more effectively⁹¹ and enable them to prioritize complaints that have “the greatest impact on patient protection” and the “closest link to fitness to practice.”⁹² Cases involving torture or other forms of cruel, inhuman, or degrading treatment may in some cases need comparatively high levels of resources for adequate investigation.

State governments bear responsibility for funding disciplinary boards to investigate, prosecute, and adjudicate misconduct complaints adequately. Additionally, insofar as the DoD and other federal agencies rely on the state licensure and disciplinary system to regulate health professionals in their employ, Congress should contribute resources to ensure their effectiveness. The funds could be distributed according to the number of licensees in each state employed by a federal agency requiring licensure.

Congress should require the DoD, CIA, and other federal agencies to cooperate in state board investigations in allegations of torture or other forms of cruel, inhuman, or degrading treatment

The DoD relies on state licensing to establish the qualifications, competence, and character of its health professionals, and reports disciplinary actions to national databases that are available to state disciplinary authorities.⁹³ As a result, facilitating adherence to licensure standards, reporting misconduct, and cooperating with state investigations should be understood as obligations by the DoD. Federal agencies, however, do not currently have an explicit statutory duty to provide evidence germane to the exercise of state disciplinary board functions in connection with actions undertaken during military service.⁹⁴ Congress should fill

this gap by ensuring that federal agencies make evidence available to state disciplinary boards where a bona fide complaint of misconduct is made, with appropriate safeguards for handling classified information.⁹⁵

Federal law should provide legal protection from reprisal to those who report health professionals to state disciplinary boards for suspected participation or complicity in torture or cruel, inhuman, or degrading treatment

Fear of reprisals may deter individuals from reporting human rights abuses in national security detention centers, thus thwarting the mission of state medical boards and preventing abuses from being sanctioned. In other contexts, whistleblower protection has been recognized as important to preserving the public interest and ensuring that claims against wrongdoing are actually brought forward. Whistleblower protections are written into six environmental statutes and prevent retaliatory action by employers against employees who report environmental violations.⁹⁶ Similarly, several occupational safety acts provide anti-retaliation protections for employees who report safety violations in the workplace.⁹⁷ The Internal Revenue Service also maintains a successful whistleblower program. Effective legal protections do not necessarily require absolute immunity for complainants, but should encompass protection that includes maintaining confidentiality and preventing retaliation. Given the federal government’s stated interest in preventing torture and the fact that most potential complainants will be employed by the military, expanding federal whistleblower protection to include military and intelligence health professionals who report misconduct to state medical boards is needed.

Conclusion

The inadequacy of existing state mechanisms to hold health professionals accountable for torture and other forms of cruel, inhuman, or degrading treatment of detainees must be remedied to protect the public, reinforce norms and expectations, and sanction wrongdoers. The actions needed are straightforward, but will require action at the state legislative and national level. Initiatives have begun in some state legislatures in Massachusetts and New York, which can become models for other states.

Task Force Members

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Vincent Iacopino, MD, PhD, is Senior Medical Advisor to Physicians for Human Rights and Adjunct Professor of Medicine with the University of Minnesota Medical School. For the past 20 years, he has participated in dozens of health and human rights investigations. He was the principal organizer of an international effort to develop UN guidelines on effective investigation and documentation of torture and cruel, inhuman, or degrading treatment (the Istanbul Protocol) and has served as a consultant to the United Nations High Commissioner for Human Rights. Dr. Iacopino is also a Senior Research Fellow at the Human Rights Center of the University of California, Berkeley, and has taught Health and Human Rights courses at Berkeley since 1995. Dr. Iacopino is the author of more than 85 health and human rights publications. In 2004, he received The Center for Victims of Torture's Eclipse Award for extraordinary service on behalf of torture survivors. In 2005, he also received the Distinguished Alumni Award from the Department of Medicine of the University of Minnesota.

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Steven H. Miles, MD, is Professor of Medicine and Maas Family Foundation Chair in Bioethics at the University of Minnesota. He studies physician complicity with torture and war crimes and is currently addressing the increasing international movement to hold physicians accountable for this kind of criminal or professional misconduct. He has also written on U.S. physicians' human rights misconduct during the war on terror. He wrote *Oath Betrayed: America's Torture Doctors*. He maintains an online archive of 50,000 U.S. documents recording the policies and misconduct of war-on-terror physicians.

ARYEH NEIER*President Emeritus, Open Society Foundations*

Aryeh Neier is President Emeritus of the Open Society Foundations, having served as President from 1993 to 2012. Previously, he was Executive Director of Human Rights Watch; before that, he was Executive Director of the American Civil Liberties Union. His most recent book is *The International Human Rights Movement: A History* (2012). He was Distinguished Visiting Professor at Sciences Po (Paris) in 2012.

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Deborah Alejandra Popowski, JD, is a Lecturer on Law and a Clinical Instructor at Harvard Law School, where she teaches courses that examine the impact of U.S. counterterrorism policy and operations and serves as Project Coordinator of the Program for Medical Professionals, Human Rights, and Humanitarian Law. Prior to her Harvard appointment, she was a Skirball Fellow at the Center for Constitutional Rights. Popowski has worked since 2008 to end the involvement of U.S. health professionals in torture through supporting legislation to reform state health professional codes, filing complaints before state licensing boards, creating a public education website, and providing support for detainees and U.S. service members and veterans who suffered medical and other health-related abuse. She is co-counsel in *Bond et al. v. Ohio State Psychology Board*, a suit seeking to compel that board to investigate a professional misconduct complaint filed by four Ohio residents against Col. (Ret.) Larry James, former senior intelligence psychologist at Guantánamo.

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Steven Reisner, PhD, is a practicing psychoanalyst and couples therapist in New York. He is a founding member of the Coalition for an Ethical Psychology, a group dedicated to upholding international standards of human rights in psychological practice and research and supporting psychologists who work to combat the effects of political violence and oppression internationally. Dr. Reisner is advisor on psychology and ethics for Physicians for Human Rights. With Physicians for Human Rights and the Coalition, Dr. Reisner has been working to change the policy of the American Psychological Association supporting psychologists' participation in coercive or abusive military/intelligence interrogations at places like Guantánamo, Bagram, and CIA "black sites." Because of this work, Dr. Reisner was the recipient of the New York State Psychological Association's Beacon Award. In addition, Dr. Reisner has been a consultant on trauma and resilience in the face of catastrophic events for the United Nations, the International Criminal Court, the International Organization for Migrations, and other international humanitarian organizations.

HERNÁN REYES, MD, FMH OB/GYN

Born in 1951 in Chile, Hernán Reyes grew up in New York and then moved to Geneva, where he graduated from medical school. A trained ob/gyn with a doctorate in medicine from Geneva University, he worked for 28 years as medical coordinator for the International Committee of the Red Cross, specializing in medical and ethical aspects of human rights, prison health, and in the field of multi-drug-resistant tuberculosis (MDR TB) in prisons. He has vast field experience, having worked in well over 50 countries. He has numerous publications on these issues and recognized expertise in the documentation of torture, management of hunger strikes, and other areas.

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David J. Rothman is President of the Institute on Medicine as a Profession (IMAP) and Bernard Schoenberg Professor of Social Medicine at Columbia College of Physicians & Surgeons. Trained in American social history, he first explored the history of mental hospitals and prisons. His book *The Discovery of the Asylum* (1973) was co-winner of the American Historical Association Beveridge Prize. David Rothman joined the Columbia College of Physicians and Surgeons in 1983 and subsequently examined the history of health care practices and policies. His books include *Strangers at the Bedside* and *The Pursuit of Perfection* (2003, with Sheila Rothman). With Sheila Rothman, he has addressed human rights in medicine, including trafficking in organs, how AIDS came to infect Romanian orphans, and research ethics in third-world countries. Rothman is now advancing the role of professionalism in medicine. He has co-chaired two policy task forces, whose recommendations were published as “Health Industry Practices that Create Conflicts of Interest (JAMA, 2006) and “Professional Medical Associations and Their Relationships with Industry” (JAMA, 2009).

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Leonard S. Rubenstein is Senior Scholar and Director of the Program on Human Rights, Health, and Conflict at the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health. He previously served as Executive Director and then President of Physicians for Human Rights and as a Jennings Randolph Senior Fellow at the United States Institute for Peace. His current teaching includes a course on human rights for the public health professional. Mr. Rubenstein has written and lectured extensively on health professionals and human rights as well as conducted field investigations in Kosovo, Chechnya, Israel and the Occupied Territories, South Africa, Cameroon, and elsewhere. He co-chaired the International Dual Loyalty Working Group, which produced the report “Dual Loyalty and Human Rights in Health Professional Practice: Guidelines and Institutional Mechanisms,” and has written reports, book chapters, and articles for professional journals and op-eds in the *Washington Post* and *New York Times* on the role of health professionals in U.S. interrogation of detainees held at Guantánamo and elsewhere. Mr. Rubenstein is the recipient of many awards, including the Sidel-Levy Award for Peace of the American Public Health Association.

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Steven S. Sharfstein is President and Chief Executive Officer of the Sheppard Pratt Health System, where he has worked for 25 years. He is also Clinical Professor and Vice Chair of Psychiatry at the University of Maryland. A practicing clinician for more than 35 years, he is best known for his research and writing on the economics of practice and public mental health policy. Over a period of 13 years, he held a variety of positions at the National Institute of Mental Health, including Director of Mental Health Service Programs, as well as positions in consultation/liaison psychiatry and research in behavioral medicine on the campus of the National Institutes of Health. He has written on a wide variety of clinical and economic topics and has published more than 140 professional papers, 40 book chapters, and 10 books, including (as co-author) *Madness and Government: Who Cares for the Mentally Ill?*, a history of the federal community mental health centers program. More recently, he was chief editor of *Textbook of Hospital Psychiatry*. A graduate of Dartmouth College and the Albert Einstein College of Medicine, he trained in psychiatry at the Massachusetts Mental Health Center in Boston from 1969 to 1972. Dr. Sharfstein also received a Master in Public Administration degree from the Kennedy School of Government in 1973 and a certificate from the Advanced Management Program at the Harvard Business School in 1991. He was Secretary of the American Psychiatric Association from 1991 to 1995, its Vice President from 2002 to 2004, and President from 2005 to 2006. Dr. Sharfstein also received the Human Rights Award from the American Psychiatric Association in 2007.

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Professor Albert J. Shimkus, Jr., joined the National Security Affairs faculty in December 2006 and was appointed Course Director for the Policy Making and Process and Contemporary Staff Environment courses in May 2007. He now teaches in the Leadership sub-courses. He enlisted in the U.S. Air Force in 1965 and completed a tour of duty at Bien Hoa Air Base, South Vietnam, in 1967 and 1968. He graduated from George Washington University in 1981 with a Bachelor of Science in Nurse Anesthesia degree and practiced as a nurse anesthetist (CRNA) for over 25 years with numerous tours in support of deployed forces. He earned a Master of Arts Degree in National Security and Strategic Studies from the Naval War College in 1993. He had numerous leadership tours while on active duty, including Executive Officer, U.S. Naval Hospital, Naples, Italy; Commanding Officer, U.S. Naval Hospital, Guantánamo Bay, Cuba, and Joint Task Force Surgeon, JTF GTMO; Navy Medicine's team leader for BRAC 2005; Deputy Commandant, Naval District Washington; and Commanding Officer, medical treatment facility USNS COMFORT. Shimkus taught in the Naval War College's National Security Decision Making Department for two years as a military faculty member and in the College of Distance Education for six years. He retired from the U.S. Navy as a Captain (06) in 2007 after a 39-year career.

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Eric Stover is Faculty Director of the Human Rights Center and Adjunct Professor of Law at the University of California, Berkeley. His research on the medical and social consequences of landmines helped launch the International Campaign to Ban Land Mines, which received the Nobel Prize in 1997. His most recent books include *The Guantánamo Effect: Exposing the Consequences of U.S. Interrogation and Detention Practices* (with Laurel Fletcher) and *The Witnesses: War Crimes and the Promise of Justice in The Hague*.

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Dr. Thomson was previously Executive Vice President for Professional Affairs and Chief of Staff at the Columbia-Presbyterian Medical Center, and Director of Medicine at Harlem Hospital Center. He has served on numerous National Institutes of Health committees on hypertension, cardiovascular disease, and clinical trials. He was Chairman of the Board of Directors of the Institute on Medicine as a Profession from 2003 to 2011. Dr. Thomson is a member of the Institute of Medicine of the National Academies (IOM) and was Chairman of a 2004 IOM committee that reviewed and reported on the Health Disparities Research Plan of the National Institutes of Health. He served as a member of the Constitution Project Task Force on Detainee Treatment, which presented its report in April 2013. He is also a former Chairman of the American Board of Internal Medicine and Past President of the American College of Physicians.

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Dr. Turton attended medical school at Emory University and trained in internal medicine at Vanderbilt University. He has a Master of Business Administration degree from the University of South Florida. He has practiced in a variety of settings, including community-based private practice, university-based teaching hospital, the National Health Service Corps, and primary care in an academic medical center. He has been involved in hospital leadership in a variety of roles, formation of a large medical group, independent practice associations, health insurance companies, and professional liability companies. Additionally, he has extensive experience in professional medical associations, especially the American College of Physicians, where he was Chair of the Professionalism and Human Rights Committee and Chair of the Board of Regents. Currently he is Medical Director of General Internal Medicine at Emory University Hospital Midtown and Assistant Professor of Medicine at Emory University School of Medicine.

BRIGADIER GENERAL (RET.) STEPHEN N. XENAKIS, MD

Dr. Xenakis served 28 years in the United States Army as a medical corps officer. He held a wide variety of assignments as a clinical psychiatrist, staff officer, and senior commander, including Commanding General of the Southeast Army Regional Medical Command. Dr. Xenakis has written widely on medical ethics, military medicine, and the treatment of detainees. He has published editorials in the *New York Times*, *Washington Post*, and a number of other national magazines and journals. He has also published book chapters and legal reviews. Dr. Xenakis has an active clinical and consulting practice and currently is working on the clinical applications of quantitative electroencephalography (QEEG) to brain injury and other neurobehavioral conditions.

*Appendix 1: Istanbul Protocol Guidelines
for Medical Evaluations of Torture and Cruel,
Inhuman or Degrading Treatment, Annex 4*

I. CASE INFORMATION

Date of Exam: _____

Exam. Requested By (Name/Position): _____

Case ID/Report #: _____

Duration of Evaluation: Hours Minutes _____

Subject's Given Name: Birth Date: Birth Place: _____

Subject's Family Name: Gender: Female/Male

Reason for Exam: Subject's ID#: _____

Clinician's Name: _____

Interpreter: Yes/No Name: _____

Informed Consent: Yes/No - If "No," Provide Reason: _____

Subject Accompanied By (Name/Position): _____

Person(s) Present During Examination (Name/Position): _____

Subject Restrained During Exam: Yes/No - If "Yes," How/Why

Medical Report Transferred to (Name/Position/ID#): _____

Transfer Date: Transfer Time: _____

Medical Evaluation/Investigation Conducted without Restriction

(For Subjects in Custody): Yes/No

Provide Details of Any Restrictions: _____

II. CLINICIAN'S QUALIFICATIONS *(For Judicial Testimonies)*

1. Medical Education and Clinical Training
2. Psychological/Psychiatric Training
3. Experience in Documenting Evidence of Torture and Cruel, inhuman or degrading treatment
4. Regional Human Rights Expertise Relevant to the Investigation
5. Relevant Publications, Presentations and Training Courses
6. Provide Curriculum Vitae

III. STATEMENT REGARDING VERACITY OF TESTIMONY *(For Judicial Testimonies)*

For example: "I personally know the facts recited below, except as to those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. BACKGROUND INFORMATION

1. General Information
(age, occupation, education, family composition, etc.)
2. Past Medical History
3. Review of Prior Medical Evaluations of Torture and Cruel, inhuman or degrading treatment
4. Psychosocial History Pre-Arrest

V. ALLEGATIONS OF TORTURE AND CRUEL, INHUMAN OR DEGRADING TREATMENT

1. Summary of Detention(s) and Abuse
2. Circumstances of Arrest and Detention
3. Initial and Subsequent Places of Detention

(chronology, transportation, and detention conditions)

4. Narrative Account of Cruel, inhuman or degrading treatment of Torture (in each place of detention)
5. Review of Torture Methods

VI. PHYSICAL SYMPTOMS AND DISABILITIES

Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute Symptoms and Disabilities
2. Chronic Symptoms and Disabilities

VII. PHYSICAL EXAMINATION

1. General Appearance
2. Skin
3. Face/Head
4. Eyes/Ears/Nose/Throat
5. Oral Cavity/Teeth
6. Chest/Abdomen (including vital signs)
8. Musculoskeletal System
9. Nervous System (Central and Peripheral)

VIII. PSYCHOLOGICAL HISTORY/EXAMINATION

1. Methods of Assessment
2. Current Psychological Complaints
4. Pre-Torture History
5. Past Psychological/Psychiatric History

6. Substance Use and Abuse History
7. Mental Status Examination
8. Assessment of Social Functioning
9. [Psychological Testing]
10. [Neuropsychological]

IX. PHOTOGRAPHS

X. DIAGNOSTIC TEST RESULTS

XI. CONSULTATIONS

XII. INTERPRETATION OF FINDINGS

1. Physical Evidence:
 - A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.
 - B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or cruel, inhuman or degrading treatment was inflicted.)
 - C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.
2. Psychological Evidence:
 - A. Correlate the degree of consistency between the psychological findings and the alleged report of torture.A.
 - B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.

- C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time; i.e., what is the time frame in relation to the torture events and where in the course of recovery is the individual.
- D. Identify any coexisting stressors impinging on the individual (e.g., ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.
- E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture and/or detention.

XIII. CONCLUSIONS AND RECOMMENDATIONS

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and cruel, inhuman or degrading treatment.
2. Reiterate the symptoms and/or disabilities that the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and/or care for the individual.

XIV. STATEMENT OF TRUTHFULNESS *(For Judicial Testimonies)*

For example, “I declare under penalty of perjury, pursuant to the laws of (XX country), that the foregoing is true and correct and that this affidavit was executed on X/X/X at (City), (State or Province).”

Xv. STATEMENT OF RESTRICTIONS ON THE MEDICAL EVALUATION/INVESTIGATION *(For Subjects in Custody)*

For example, “The undersigned clinician(s) personally certify that they were allowed to work freely and independently, and permitted to speak with and examine (the subject) in private, without any restriction or reservation,

and without any form of coercion being used by the detaining authorities;”
or alternatively: “The undersigned clinician(s) had to carry out his/her/their
evaluation/investigation with the following restrictions:...”

Clinician’s Signature, Date, Place

XVII. RELEVANT APPENDICES

e.g. Clinician’s Curriculum Vitae, Anatomical Drawings for Identification
of Torture and Cruel, inhuman or degrading treatment, Photographs,
Consultations, and Diagnostic Test Results, among others.

Appendix 2: World Medical Association Declaration of Malta on Hunger Strikers (revised 2006)

PREAMBLE

1. Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres). They are often a form of protest by people who lack other ways of making their demands known. In refusing nutrition for a significant period, they usually hope to obtain certain goals by inflicting negative publicity on the authorities. Short-term or feigned food refusals rarely raise ethical problems. Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians. Hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. Physicians need to ascertain the individual’s true intention, especially in collective strikes or situations where peer pressure may be a factor. An ethical dilemma arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment. The principle of beneficence urges physicians to resuscitate them but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made. An added difficulty arises in custodial settings because it is not always clear whether the hunger striker’s advance instructions were made voluntarily and with appropriate information about the consequences. These guidelines and the background paper address such difficult situations.

PRINCIPLES

2. Duty to act ethically. All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy. Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.

3. Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made involuntarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.
4. 'Benefit' and 'harm'. Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or *primum non nocere*. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.
5. Balancing dual loyalties. Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients. Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient.
6. Clinical independence. Physicians must remain objective in their assessments and not allow third parties to influence their medical judgment. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.
7. Confidentiality. The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously harms others. As with other patients, hunger strikers' confidentiality should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm. If individuals agree, their relatives and legal advisers should be kept informed of the situation.
8. Gaining trust. Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimises harm to them.

Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.

GUIDELINES FOR THE MANAGEMENT OF HUNGER STRIKERS

9. Physicians must assess individuals' mental capacity. This involves verifying that an individual intending to fast does not have a mental impairment that would seriously undermine the person's ability to make health care decisions. Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers. They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health.
10. As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast. The medical implications of any existing conditions should be explained to the individual. Physicians should verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages. Physicians should also explain how damage to health can be minimised or delayed by, for example, increasing fluid intake. Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical. Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient to repeat back what they understand.
11. A thorough examination of the hunger striker should be made at the start of the fast. Management of future symptoms, including those unconnected to the fast, should be discussed with hunger strikers. Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted.
12. Sometimes hunger strikers accept an intravenous saline solution transfusion or other forms of medical treatment. A refusal to accept certain interventions must not prejudice any other aspect of the medical care, such as treatment of infections or of pain.

13. Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees. Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.
14. Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice. Hunger strikers should be protected from coercion. Physicians can often help to achieve this and should be aware that coercion may come from the peer group, the authorities or others, such as family members. Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike.
15. If a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal.
16. Continuing communication between physician and hunger strikers is critical. Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want to be done when they are no longer able to communicate meaningfully. These findings must be appropriately recorded.
17. When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. Consideration needs to be given to any advance instructions made by the hunger striker. Advance refusals of treatment demand respect if they reflect the voluntary wish of the individual when competent. In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered. Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution. If well-informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because the situation in which the decision was made has changed radically since the individual lost competence.
18. If no discussion with the individual is possible and no advance instructions exist, physicians have to act in what they judge to be the person's best interests. This means considering the hunger strikers'

- previously expressed wishes, their personal and cultural values as well as their physical health. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.
19. Physicians may consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress. If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will.
 20. Artificial feeding can be ethically appropriate if competent hunger strikers agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.
 21. Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

*Appendix 3: Ethics Statements and
Opinions of Professional Associations on
Interrogation and Torture*

World Medical Association

*Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other
Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and
Imprisonment (1975, revised 2005 and 2006)*

PREAMBLE

It is the privilege of the physician to practice medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity. For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

DECLARATION

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities. 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.
4. The physician shall not be present during any procedure during which torture or any other form of cruel, inhuman or degrading treatment is used or threatened.
5. A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The 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 higher purpose.
6. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.
7. The World Medical Association will support, and should encourage the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

American Medical Association

Code of Medical Ethics,

Opinion 2.067 - Torture (December 1999)

Torture refers to the deliberate, systematic, or wanton administration of cruel, inhuman, and degrading treatments or punishments during imprisonment or detainment. Physicians must oppose and must not participate in torture for any

reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened. Physicians may treat prisoners or detainees if doing so is in their interest, but physicians should not treat individuals to verify their health so that torture can begin or continue. Physicians who treat torture victims should not be persecuted. Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great.

Physician Participation

in Interrogation (November 2006)

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations are distinct from questioning used by physicians to assess the physical or mental condition of an individual. To be appropriate, interrogations must avoid the use of coercion—that is, threatening or causing harm through physical injury or mental suffering. In this Opinion, “detainee” is defined as a criminal suspect, prisoner of war, or any other individual who is being held involuntarily. Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics. Questions about the propriety of physician participation in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to individuals with obligations to protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest. Applying this general approach, physician involvement with interrogation during law enforcement or intelligence gathering should be guided by the following:

1. Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.
2. Physicians 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.

3. Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in the interrogation.
4. Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.
5. When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

American College of Physicians

Ethics Statement

on Physicians and Torture (2008)

- Physicians must not be party to and must speak out against torture or other abuses of human rights.
- Participation by physicians in the execution of prisoners except to certify death is unethical.
- Under no circumstances is it ethical for a physician to be used as an instrument of government to weaken the physical or mental resistance of a human being, nor should a physician participate in or tolerate cruel or unusual punishment or disciplinary activities beyond those permitted by the United Nations Standard Minimum Rules for the Treatment of Prisoners.
- Physicians must not conduct, participate in, monitor, or be present at interrogations, or participate in developing or evaluating interrogation strategies or techniques.
- A physician who becomes aware of abusive or coercive practices has a duty to report those practices to the appropriate authorities and advocate for necessary medical care.
- Exploiting, sharing, or using medical information from any source for interrogation purposes is unethical.

American Psychiatric Association

Position Statement

on Human Rights (December 1992)

The American Psychiatric Association is concerned about the psychiatric consequences of human rights violations—violations such as unjust incarceration and cruel or unusual punishment, including terror and torture. The World Psychiatric Association goals include: to educate psychiatrists and other professionals about human rights abuses and the persecution of physicians who speak out against the use of torture and for the rehabilitation of torture victims; to promote research on the effects of human rights violations; and to prevent human rights violations.

Psychiatric Participation

in Interrogation of Detainees (May 2006)

1. The American Psychiatric Association reiterates its position that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person. Psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons to take corrective action.
2. a) Every person in military or civilian detention, whether in the United States or elsewhere, is entitled to appropriate medical care under domestic and international humanitarian law. b) Psychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients, including advocating for their patients, and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military or civilian agencies or law enforcement authorities. c) Psychiatrists should not disclose any part of the medical records of any patient, or information derived from the treatment relationship, to persons conducting interrogation of the detainee. d) This paragraph is not meant to preclude treating psychiatrists who become aware that the detainee may pose a significant threat of harm to him/herself or to others from ascertaining the nature and the seriousness of the threat or from notifying appropriate authorities of that threat, consistent with the obligations applicable to other treatment relationships.
3. 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, psychiatrists 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.

American Psychological Association

American Psychological Association

Opposition to Torture (1986)

WHEREAS the American psychologists are bound by the Ethical Principles to “respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights and;

WHEREAS the existence of state-sponsored torture and other cruel, inhuman, or degrading treatment has been documented in many nations around the world and;

WHEREAS psychological knowledge and techniques may be used to design and carry out torture and;

WHEREAS torture victims may suffer from long-term, multiple psychological and physical problems,

BE IT RESOLVED that the American Psychological Association condemns torture wherever it occurs, and

BE IT FURTHER RESOLVED that the American Psychological Association supports the U.N. Declaration and Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the U.N. Principles of Medical Ethics, as well as the joint congressional Resolution opposing torture that was signed into law by President Reagan on October 4, 1984.

Recommendations of the American Psychological Association

Task Force on Psychological Ethics and National Security,

adopted by Council of Representative (2006, footnotes omitted)

1. Psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment.

The Task Force endorses the 1986 Resolution Against Torture of the American Psychological Association Council of Representatives, and the

1985 Joint Resolution Against Torture of the American Psychological Association and the American Psychiatric Association. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm) The Task Force emphasizes that the Board of Directors’ charge did not include an investigative or adjudicatory role and so the Task Force does not render any judgment concerning events that may or may not have occurred in national security-related settings. The Task Force nonetheless feels that an absolute statement against torture and other cruel, inhuman, or degrading treatment is appropriate.

2. **Psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities.** This ethical responsibility is rooted in the Preamble, “Psychologists respect and protect civil and human rights...the development of a dynamic set of ethical standards for psychologists’ work-related conduct requires a personal commitment and lifelong effort to act ethically [and] to encourage ethical behavior by...colleagues,” and Principle B, Fidelity and Responsibility, which states that psychologists “are concerned about the ethical compliance of their colleagues’ scientific and professional conduct.” (Ethical Standard 1.05, Reporting Ethical Violations) The Task Force notes that when fulfilling the obligation to respond to unethical behavior by reporting the behavior to appropriate authorities as a prelude to an adjudicatory process, psychologists guard against the names of individual psychologists being disseminated to the public. Inappropriate or premature public dissemination can expose psychologists to a risk of harm outside of established and appropriate legal and adjudicatory processes. (Ethical Standard 3.04, Avoiding Harm)
3. **Psychologists who serve in the role of supporting an interrogation do not use health care-related information from an individual’s medical record to the detriment of the individual’s safety and well-being.** While information from a medical record may be helpful or necessary to ensure that an interrogation process remains safe, psychologists do not use such information to the detriment of an individual’s safety and well-being. (Ethical Standards 3.04, Avoiding Harm, and 3.08, Exploitative Relationships)
4. **Psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons**

to follow laws or orders that are unjust or that violate basic principles of human rights. Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of, familiar with, and follow the most recent applicable regulations and rules. The Task Force notes that certain rules and regulations incorporate texts that are fundamental to the treatment of individuals whose liberty has been curtailed, such as the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War. The Task Force notes that psychologists sometimes encounter conflicts between ethics and law. When such conflicts arise, psychologists make known their commitment to the APA Ethics Code and attempt to resolve the conflict in a responsible manner. If the conflict cannot be resolved in this manner, psychologists may adhere to the requirements of the law. (Ethical Standard 1.02) An ethical reason for psychologists to not follow the law is to act “in keeping with basic principles of human rights.” (APA Ethics Code, Introduction and Applicability) The Task Force encourages psychologists working in this area to review essential human rights documents, such as the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War.

- 5. Psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous.** Psychologists have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that psychologists are serving in a health care provider role. (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations). The Task Force noted that psychologists acting in the role of consultant to national security issues most often work closely with other professionals from various disciplines. As a consequence, psychologists rarely act alone or independently, but rather as part of a group of professionals who bring together a variety of skills and experiences in order to provide an ethically appropriate service. (Ethical Standard 3.09, Cooperating with

Other Professionals) Regardless of their role, psychologists who are aware of an individual in need of health or mental health treatment may seek consultation regarding how to ensure that the individual receives needed care. (Principle A, Beneficence and Nonmaleficence)

- 6. Psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships.** (Ethical Standard 3.05, Multiple Relationships, “A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.”)
- 7. Psychologists may serve in various national security-related roles, such as a consultant to an interrogation, in a manner that is consistent with the Ethics Code, and when doing so psychologists are mindful of factors unique to these roles and contexts that require special ethical consideration.** The Task Force noted that psychologists have served in consultant roles to law enforcement on the state and federal levels for a considerable period of time. Psychologists have proven highly effective in lending assistance to law enforcement in the vital area of information gathering and have done so in an ethical manner. The Task Force noted special ethical considerations for psychologists serving as consultants to interrogation processes in national security-related settings, especially when individuals from countries other than the United States have been detained by United States authorities. Such ethical considerations include:
1. How certain settings may instill in individuals a profound sense of powerlessness and may place individuals in considerable positions of disadvantage in terms of asserting their interests and rights. (Ethical Standards 1.01, Misuse of Psychologists’ Work, and 3.08, Exploitative Relationships)
 2. How failures to understand aspects of individuals’ culture and ethnicity may generate misunderstandings, compromise the efficacy and hence the safety of investigatory processes, and result in significant mental and physical harm. (Principle E, “Psychologists are aware of and respect cultural, individual, and role differences,

including those based on race, ethnicity, culture, national origin... and consider these factors when working with members of such groups"; Ethical Standard 2.01(b), Boundaries of Competence, "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with race, ethnicity, culture, national origin... is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals..."; and Ethical Standard 3.01, Unfair Discrimination, "In their work-related activities, psychologists do not engage in unfair discrimination based on race, ethnicity, culture, national origin..."

3. How the combination of a setting's ambiguity with high stress may facilitate engaging in behaviors that cross the boundaries of competence and ethical propriety. As behavioral scientists, psychologists are trained to observe, respond to, and ideally correct such processes as they occur. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm)
8. **Psychologists who consult on interrogation techniques are mindful that the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator.** This ethical obligation is not diminished by the nature of an individual's acts prior to detainment or the likelihood of the individual having relevant information. At all times psychologists remain mindful of and abide by the prohibitions against engaging in or facilitating torture and other cruel, inhuman, or degrading treatment. Psychologists inform themselves about research regarding the most effective and humane methods of obtaining information and become familiar with how culture may interact with the techniques consulted upon. (Principle E, Respect for Peoples' Rights and Dignity; Ethical Standards 2.01, Boundaries of Competence; 2.03, Maintaining Competence; and 3.01, Unfair Discrimination)
9. **Psychologists make clear the limits of confidentiality.** (Ethical Standard 4.02, Discussing the Limits of Confidentiality) Psychologists who have access to, utilize, or share health or mental health-related information do so with an awareness of the sensitivity of such

information, keeping in mind that, "Psychologists have a primary obligation and take reasonable precautions to protect confidential information..." (Ethical Standard 4.01, Maintaining Confidentiality)

When disclosing sensitive information, psychologists share the minimum amount of information necessary, and only with individuals who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) Psychologists take care not to leave a misimpression that information is confidential when in fact it is not. (Ethical Standards 3.10, Informed Consent, and 4.02, Discussing the Limits of Confidentiality)

10. **Psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code.** (Ethical Standard 2.02, Providing Services in Emergencies) Psychologists strive to ensure that they rely on methods that are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01, Bases for Assessments)
11. **Psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients.** (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations) Regardless of whether an individual is considered a client, psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, and ethical. (Ethical Standard 3.04, Avoiding Harm) Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..."; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; Principle E, Respect for People's Rights and Dignity, "Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision-making"; Ethical Standard 3.08, Exploitative Relationships)

12. Psychologists consult when they are facing difficult ethical dilemmas. The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, “The development of a dynamic set of ethical standards for psychologists’ work-related conduct requires a personal commitment and lifelong effort to act ethically...and to consult with others concerning ethical problems”; and Ethical Standard 4.06, Consultations)

American Psychological Association resolution against torture and other cruel, inhuman, and degrading treatment or punishment (2006, footnotes omitted)

WHEREAS the existence of state-sponsored torture and other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment has been documented in many nations around the world (e.g., Genefke, 2004; Human Rights Watch, 2006; U.S. Department of State, 2005);

WHEREAS torture victims and victims of other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment may suffer from long-term, multiple psychological and physical problems (e.g., Carlsson, Mortensen, & Kastrup, 2005; Gerrity, Keane, & Tuma, 2001; Hermansson, Timpka, & Thyber, 2003; Kanninen, Punamaki, & Qouta, 2003; Somnier, Vesti, Kastrup, & Genefke, 1992);

WHEREAS psychological knowledge and techniques (e.g., including but not limited to deprivation and disorientation techniques) may be used to design and carry out torture and other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment (e.g., Conroy, 2000; Hovens & Drozdek, 2002; Mossallanejad, 2000);

WHEREAS the Ethical Principles of the APA Ethical Principles of Psychologists and Code of Conduct (2002) call upon members of the APA to respect the inherent dignity and worth of the individual and strive for the preservation and protection of fundamental human rights recognizing the equal and inalienable rights of all members of the human family;

WHEREAS in 2000 APA received consultative status as a non-governmental organization (NGO) at the United Nations (UN) in recognition of evidence provided by APA of its efforts to promote human rights;

WHEREAS as an accredited NGO at the UN, the APA is committed to the spirit, purposes, and principles of the Charter of the UN and other relevant international instruments;

WHEREAS APA’s status as an accredited NGO at the UN carries the commitment to promote and protect human rights in accordance with the Charter of the UN and the Universal Declaration of Human Rights and to contribute its expertise and resources to the implementation of the various human rights declarations, conventions and other standards of the UN;

WHEREAS, consistent with its history in supporting human rights, in its 1987 Human Rights Resolution, APA issued a strong statement that “the discipline of psychology, and the academic and professional activities of psychologists, are relevant for securing and maintaining human rights”; and undertook to promote knowledge of and compliance with UN instruments by resolving to commend the main UN human rights instruments and documents to the attention of its boards, committees and membership at large;

WHEREAS in its 1986 Resolution Against Torture, APA supported the United Nations Declaration and Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment;

WHEREAS the American Psychological Association 1986 Human Rights Resolution is specific in its support for the United Nations 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, which includes Principle 4a, “It is a contravention of medical ethics for health personnel.. .to apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments”;

WHEREAS the American Psychological Association 1986 Human Rights Resolution is specific in its support for the joint congressional Resolution opposing torture that was signed into law by President Reagan on October 4, 1984;

WHEREAS in August 2005 APA’s Council of Representatives approved the motion to acknowledge Principle 2.2 of the United Nations Convention Against Torture and Other Cruel, Inhuman, and Degrading Treatment or Punishment, which states that “[T]here are no exceptional circumstances whatsoever, whether induced by a state of war or threat of war, internal political instability or any other public emergency, that may be invoked as a justification for torture, including the invocation of laws, regulations, or orders”;

BE IT RESOLVED that the APA reaffirms its 1986 condemnation of torture and other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment wherever it occurs;

BE IT RESOLVED that the APA reaffirms its support for the United Nations Declaration and Convention Against Torture and Other Cruel, Inhuman, or

Degrading Treatment or Punishment and its adoption of Article 2.2, which states “[T]here are no exceptional circumstances whatsoever, whether induced by a state of war or a threat of war, internal political instability or any other public emergency, that may be invoked as a justification of torture”;

BE IT RESOLVED that, in accordance with Article 1 of the United Nations Declaration and Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, “[T]he term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted upon 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 [e.g., governmental, religious, political, organizational] capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions [in accordance with both domestic and international law]”;

BE IT RESOLVED, that the term “cruel, inhuman, or degrading treatment or punishment” means treatment or punishment by a psychologist that, in accordance with the McCain Amendment, is of a kind that would be “prohibited by the Fifth, Eighth, and Fourteenth Amendments to the Constitution of the United States, as defined in the United States Reservations, Declarations and Understandings to the United Nations Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment done at New York, December 10, 1984.”

BE IT RESOLVED that, based upon the American Psychological Association 1986 Human Rights Resolution, the APA reaffirms its support for the United Nations Declaration and Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, 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 as well as the joint congressional Resolution opposing torture that was signed into law by President Reagan on October 4, 1984, and further supports the McCain Amendment, the United Nations Basic Principles for the Treatment of Prisoners, and the United Nations Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment;

BE IT RESOLVED that based upon the APA’s long-standing commitment to basic human rights, including its position against torture, psychologists shall work

in accordance with international human rights instruments relevant to their roles;

BE IT RESOLVED that regardless of their roles, psychologists shall not knowingly engage in, tolerate, direct, support, advise, or offer training in torture or other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment;

BE IT RESOLVED that psychologists shall not provide knowingly any research, instruments, or knowledge that facilitates the practice of torture or other forms of cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment;

BE IT RESOLVED that psychologists shall not knowingly participate in any procedure in which torture or other forms of cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment is used or threatened;

BE IT RESOLVED that should torture or other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment evolve during a procedure where a psychologist is present, the psychologist shall attempt to intervene to stop such behavior, and failing that exit the procedure;

BE IT RESOLVED that psychologists shall be alert to acts of torture and other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment and have an ethical responsibility to report these acts to the appropriate authorities;

BE IT FURTHER RESOLVED that, consistent with the August 2005 action of Council, the APA will continually disseminate and publicize this 2006 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, both within the Association (to boards, committees, and the membership at large) and to the wider public.

Reaffirmation of the American Psychological Association position against torture and other cruel, inhuman or degrading treatment or punishment, and its application to individuals defined in the United States as “enemy combatants” (2007, amended 2008, footnotes omitted)

WHEREAS the mission of the American Psychological Association is to advance psychology as a science and profession and as a means of promoting health, education and human welfare through the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association;

WHEREAS the American Psychological Association is an accredited non-governmental organization at the United Nations and so is committed to promote and protect human rights in accordance with the United Nations Charter and the Universal Declaration of Human Rights;

WHEREAS the American Psychological Association passed the 2006 Resolution Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, a comprehensive and foundational position applicable to all individuals, in all settings and in all contexts without exception;

WHEREAS in 2006, the American Psychological Association defined torture in accordance with Article 1 of the United Nations Declaration and Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment,

[T]he term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted upon 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 [e.g., governmental, religious, political, organizational] capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions [in accordance with both domestic and international law];

WHEREAS in 2006, the American Psychological Association defined the term “cruel, inhuman, or degrading treatment or punishment” to mean treatment or punishment by a psychologist that, in accordance with the McCain Amendment, is of a kind that would be “prohibited by the Fifth, Eighth, and Fourteenth Amendments to the Constitution of the United States, as defined in the United States Reservations, Declarations and Understandings to the United Nations Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment done at New York, December 10, 1984.” Specifically, United States Reservation I.1 of the Reservations, Declarations and Understandings to the United Nations Convention Against Torture stating, “the term ‘cruel, inhuman or degrading treatment or punishment’ means the cruel, unusual and inhumane treatment or punishment prohibited by the Fifth, Eighth, and/or Fourteenth Amendments to the Constitution of the United States”;

BE IT RESOLVED that the American Psychological Association reaffirms unequivocally the 2006 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment in its entirety in both substance and content;

BE IT RESOLVED that the American Psychological Association affirms that there are no exceptional circumstances whatsoever, whether induced by a state of war or threat of war, internal political instability or any other public emer-

gency, that may be invoked as a justification for torture or cruel, inhuman, or degrading treatment or punishment, including the invocation of laws, regulations, or orders;

BE IT RESOLVED that the American Psychological Association unequivocally condemns torture and cruel, inhuman, or degrading treatment or punishment, under any and all conditions, including detention and interrogations of both lawful and unlawful enemy combatants as defined by the U.S. Military Commissions Act of 2006;

BE IT RESOLVED that the unequivocal condemnation includes an absolute prohibition against psychologists knowingly planning, designing, and assisting in the use of torture and any form of cruel, inhuman or degrading treatment or punishment;

BE IT RESOLVED that this unequivocal condemnation includes all techniques considered torture or cruel, inhuman or degrading treatment or punishment under the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; the Geneva Conventions; the 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; the Basic Principles for the Treatment of Prisoners; or the World Medical Association Declaration of Tokyo. An absolute prohibition against the following techniques therefore arises from, is understood in the context of, and is interpreted according to these texts: mock executions; waterboarding or any other form of simulated drowning or suffocation; sexual humiliation; rape; cultural or religious humiliation; exploitation of fears, phobias or psychopathology; induced hypothermia; the use of psychotropic drugs or mind-altering substances; hooding; forced nakedness; stress positions; the use of dogs to threaten or intimidate; physical assault including slapping or shaking; exposure to extreme heat or cold; threats of harm or death; isolation; sensory deprivation and over-stimulation; sleep deprivation; or the threatened use of any of the above techniques to an individual or to members of an individual’s family. Psychologists are absolutely prohibited from knowingly planning, designing, participating in or assisting in the use of all condemned techniques at any time and may not enlist others to employ these techniques in order to circumvent this resolution’s prohibition;

BE IT RESOLVED that the American Psychological Association calls on the United States government—including Congress, the Department of Defense, and the Central Intelligence Agency—to prohibit the use of these methods in all interrogations and that the American Psychological Association shall inform relevant parties with the United States government that psychologists are prohibited from participating in such methods;

BE IT RESOLVED that the American Psychological Association, in recognizing that torture and other cruel, inhuman or degrading treatment and punishment can result not only from the behavior of individuals, but also from the conditions of confinement, expresses grave concern over settings in which detainees are deprived of adequate protection of their human rights, affirms the prerogative of psychologists to refuse to work in such settings, and will explore ways to support psychologists who refuse to work in such settings or who refuse to obey orders that constitute torture;

BE IT RESOLVED that the American Psychological Association asserts that any APA member with knowledge that a psychologist, whether an APA member or non-member, has engaged in torture or cruel, inhuman, or degrading treatment or punishment, including the specific behaviors listed above, has an ethical responsibility to abide by Ethical Standard 1.05, --, in the *Ethical Principles of Psychologists and Code of Conduct (2002)* and directs the Ethics Committee to take appropriate action based upon such information, and encourages psychologists who are not APA members also to adhere to Ethical Standard 1.05;

BE IT RESOLVED that the American Psychological Association commends those psychologists who have taken clear and unequivocal stands against torture and cruel, inhuman or degrading treatment or punishment, especially in the line of duty, and including stands against the specific behaviors or conditions listed above; and that the American Psychological Association affirms the prerogative of psychologists under the *Ethical Principles of Psychologists and Code of Conduct (2002)* to disobey law, regulations or orders when they conflict with ethics;

BE IT RESOLVED that the American Psychological Association asserts that all psychologists with information relevant to the use of any method of interrogation constituting torture or cruel, inhuman, or degrading treatment or punishment have an ethical responsibility to inform their superiors of such knowledge, to inform the relevant office of inspector generals when appropriate, and to cooperate fully with all oversight activities, including hearings by the United States Congress and all branches of the United States government, to examine the perpetration of torture and cruel, inhuman, or degrading treatment or punishment against individuals in United States custody, for the purpose of ensuring that no individual in the custody of the United States is subjected to torture or cruel, inhuman, or degrading treatment or punishment;

BE IT RESOLVED that the APA Ethics Committee shall proceed forthwith in writing a casebook and commentary that shall set forth guidelines for psychologists that are consistent with international human rights instruments, as well as guidelines developed for health professionals, including but not limited to: Common Article 3 of the Geneva Conventions; The United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or

Punishment; The United Nations 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; and the World Medical Association Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment;

BE IT RESOLVED that the American Psychological Association, in order to protect against torture and cruel, inhuman, or degrading treatment or punishment, and in order to mitigate against the likelihood that unreliable and/or inaccurate information is entered into legal proceedings, calls upon United States legal systems to reject testimony that results from torture or cruel, inhuman, or degrading treatment or punishment.

*American Psychological Association Member Referendum
(passed 2008, footnotes omitted)*

WHEREAS torture is an abhorrent practice in every way contrary to the APA's stated mission of advancing psychology as a science, as a profession, and as a means of promoting human welfare;

WHEREAS the United Nations Special Rapporteur on Mental Health and the UN Special Rapporteur on Torture have determined that treatment equivalent to torture has been taking place at the United States Naval Base at Guantánamo Bay, Cuba;

WHEREAS this torture took place in the context of interrogations under the direction and supervision of Behavioral Science Consultation Teams (BSCTs) that included psychologists;

WHEREAS the Council of Europe has determined that persons held in CIA black sites are subject to interrogation techniques that are also equivalent to torture, and because psychologists helped develop abusive interrogation techniques used at these sites;

WHEREAS the International Committee of the Red Cross determined in 2003 that the conditions in the U.S. detention facility in Guantánamo Bay are themselves tantamount to torture, and therefore by their presence psychologists are playing a role in maintaining these conditions;

BE IT RESOLVED that psychologists may not work in settings where persons are held outside of, or in violation of, either International Law (e.g., the UN Convention Against Torture and the Geneva Conventions) or the U.S. Constitution (where appropriate), unless they are working directly for the persons being detained or for an independent third party working to protect human rights.

American Psychological Association revisions to Ethics Code

(2010, with changes to 2002 code indicated by ~~strikeout~~ for deletions and underlining for additions).

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority¹. Under no circumstances may this standard be used to justify or defend violating human rights.~~

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and ~~to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code~~. take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

Appendix 4: Professional Misconduct Complaints Filed

THE COMPLAINTS BELOW WERE FILED against health professionals affiliated with U.S. military or intelligence forces in relation to the alleged mistreatment of prisoners in the course of U.S. counterterrorism operations since 2002.¹

Complaints Against Captain John S. Edmondson, MD: California and Georgia

Captain John S. Edmondson, MD, was the commander of the Guantánamo Navy Hospital and the task force surgeon for the Joint Task Force - Guantánamo.² As such, he was the head supervisor for the medical personnel staff and was directly involved in the review of medical records and medical conditions of detainees.³ At least six professional misconduct complaints have been filed against him with medical boards in two states. None have led to formal charges.

MEDICAL BOARD OF CALIFORNIA

Mr. Saeed Ahmed Mohammed Abdullah Sarim et al. v.

Dr. John Edmondson (2005)

Complaints:

On July 11, 2005, Mr. Saeed Ahmed Mohammed Abdullah Sarim, Mr. Ali Yahya Mahdi al-Raimi, Mr. Abdul Khaliq Ahmed Saleh al-Baidhani, and Mr. Abdulaziz Abdu Abdullah Ali al-Swidi filed complaints against Dr. Edmondson with the Medical Board of California. At the time, all four complainants were detained in Guantánamo. They submitted individual medical complaints, along with news articles and opinions by medical and ethics experts. The complainants alleged that physicians and other medical personnel under the supervision of Dr.

Edmondson (1) shared personal medical information with interrogators, (2) refused necessary medical attention unless the patient cooperated with interrogators, (3) participated actively and passively in physical abuse, and (4) failed to provide basic consideration to patients in providing medical care. They alleged violations of California, national, and international standards of conduct.⁴

Board Response:

The Medical Board of California closed the complaints less than a week after receiving them, citing lack of jurisdiction.⁵

Legal Challenge:

Mr. Sarim, Mr. al-Raimi, Mr. al-Baidhani, and Mr. al-Swidi filed for a writ of mandamus in Superior Court of California and asked the court to compel the Medical Board of California to investigate the complaint. The board admitted jurisdiction but argued that they were under no obligation to reopen the case, investigate, or provide reasons for their decision not to investigate. The case was argued on January 13, 2006, before Judge Jeffrey B. Barton of the Superior Court of California, San Diego Central Civil Division.⁶ On March 16, 2006, Judge Barton sustained the demurrer and denied petition for mandamus, holding that the board had no affirmative duty to investigate public complaints.⁷

MEDICAL BOARD OF CALIFORNIA

Dr. David Nicholl v. Dr. John Edmondson (2006)

Complaint:

British physician David Nicholl filed a complaint against Dr. Edmondson with the Medical Board of California. The complaint is dated January 26, 2006.⁸ Dr. Nicholl alleged that Dr. Edmondson, in his capacity as commander of the U.S. Naval Hospital and task force surgeon for Joint Task Force - Guantánamo, had “ignored the principle of informed patient consent in his involuntary feeding technique,” amounting to a “fundamental breach of the doctor-patient relationship and a breach of State medical laws.” Dr. Nicholl also alleged breaches of “medical ethics and accepted professional standards—including a number of international declarations, including the 1975 Declaration of Tokyo on Torture, the 1991 Declaration of Malta on Hunger Strikers, as well as the guidance of the International Committee of the Red Cross (ICRC) on the management of

hunger strikes...and the United Nations Principles of Medical Ethics in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatments.” Dr. Nicholl stated that his complaint was based “entirely on the sworn testimony of Dr. Edmondson himself.” He also alleged that he had tried to “engage with Dr. Edmondson,” and that Dr. Edmondson had “refuted all allegations out of hand and refused to allow independent physicians to examine his practice and the detainees....”

Board Response:

In a letter dated July 5, 2007, Susan Cady of the Central Complaint Unit replied that the Medical Board of California did “not have jurisdiction or authority to investigate incidents that occurred on a federal facility/military base.”¹⁰ This letter was dated almost 18 months after the Medical Board of California had, in 2006 court proceedings, conceded jurisdiction over the 2005 Sarem et al. complaint also involving allegations related to Dr. Edmondson’s conduct at the U.S. Naval Station in Guantánamo Bay, Cuba.¹¹

GEORGIA COMPOSITE STATE BOARD
OF MEDICAL EXAMINERS

Dr. David Nicholl v. Dr. John Edmondson (2006)

Complaint:

Dr. Nicholl filed another formal complaint (also dated January 26, 2006) against Dr. Edmondson in Georgia, where Dr. Edmondson was also licensed.¹² The allegations were identical to those made in his complaint to the Medical Board of California.¹³

Board Response:

On June 26, 2007, in response to a letter sent by Dr. Nicholl eight days earlier inquiring as to the disposition of his complaint, Dr. Jim McNatt, medical director of the Georgia Composite State Board of Medical Examiners, communicated to Dr. Nicholl that his complaint had been “thoroughly investigated, including a thorough review of all medical records and other information gathered during the investigation.” The “[Information gathered during and for the investigation,” the letter states, “is confidential by statute.” The board concluded that “there was

not sufficient evidence to support prosecution” of Dr. Edmondson under the state’s medical practice act or the board’s rule, and left open the possibility of reconsidering the case if Dr. Nicholl were to submit additional information.¹⁴

Complaints Against Captain John Francis Leso: New York

Captain John Francis Leso allegedly led the first Behavioral Science Consultation Team (BSCT) at the U.S. Naval Station at Guantánamo from June 2002 to January 2003.¹⁵ At least two professional misconduct complaints against him have been filed with the New York Office of Professional Discipline (OPD). The OPD did not investigate either complaint.

NEW YORK OFFICE
OF PROFESSIONAL DISCIPLINE

Dr. Trudy Bond v. Dr. John Leso (2007)

Complaint:

On April 5, 2007, a civilian psychologist, Dr. Trudy Bond,¹⁶ filed a complaint against Dr. Leso with the New York State Education Department’s Office of Professional Discipline. She alleged violations of several provisions of the Rules of the Board of Regents, which govern unprofessional conduct of health professionals licensed in New York. The violations alleged included: (1) performing unduly authorized professional services, (2) failing to respond to written communications from the education department and to make available records to an inquiry or complaint, (3) abandoning or neglecting a patient or client in need of immediate care, (4) willful harassment, abuse, or intimidation of patient or client, and (5) failing to maintain an accurate patient record.¹⁷

Board Response:

Shortly after submitting the complaint, Dr. Bond reported receiving a phone call from Daniel Kelleher, OPD’s director of investigations, who said that the OPD had no jurisdiction over New York-licensed federal employees acting outside the state. Mr. Kelleher reportedly referred her subsequent questions to the deputy director of investigations. Dr. Bond reported calling the deputy director, who said to her that there would be no jurisdictional problem in pursuing the case. According to

Dr. Bond, when she informed the deputy director of his supervisor’s initial response, the deputy director said that he deferred to his supervisor and would check with him on the matter, but repeated that he did not understand why the New York office would not have jurisdiction. Neither he nor the director referenced any statutory or regulatory provision as support for the OPD’s decision. On February 29, 2008, Bond called the Central Administration Office to ask for a written decision from the OPD, and to inquire as to whether she had recourse to challenge that decision. Mr. Kelleher was not present. She was asked to call back at another time and never received a written communication.¹⁸

NEW YORK OFFICE
OF PROFESSIONAL DISCIPLINE

Dr. Steven Reisner v. Dr. John Leso (2010)

Complaint:

On July 7, 2010, New York-licensed civilian psychologist Dr. Steven Reisner¹⁹ filed a complaint against fellow New York licensee, Dr. Leso, with the OPD. Dr. Reisner’s complaint alleged that Dr. Leso “co-authored an interrogation policy memorandum that incorporated illegal techniques adapted from methods used by the Chinese and North Korean governments against U.S. prisoners of war.” Dr. Reisner further alleged that Dr. Leso “recommended a series of increasingly psychologically and physically abusive interrogation techniques to be applied against detainees held by the United States”; that “[m]any of the techniques and conditions that Dr. Leso helped put in place were applied to suspected al-Qaeda member Mohammed al-Qahtani under Dr. Leso’s direct supervision, as well as to other men and boys held at Guantánamo”; and that “[e]ventually, similar techniques were also used on detainees held in U.S. custody in Iraq and Afghanistan.”²⁰ According to Dr. Reisner, the alleged conduct violated provisions in the New York Education Law and the Rules of Regents prohibiting: (1) practice beyond authorized scope, (2) gross incompetence, (3) gross negligence, (4) unprofessional conduct, (5) conduct exhibiting a moral unfitness to practice the profession, (6) unauthorized treatment, (7) neglect of a patient in need of immediate care, (8) willful abuse and harassment, and (9) unwarranted treatment.²¹

Board Response:

In a letter dated July 28, 2010, the OPD denied jurisdiction over the complaint. OPD Director Louis Catone found “no basis for investigating” Dr. Reisner’s

complaint, stating that it did “not appear that any of the conduct complained of constitutes the practice of psychology as understood in the State of New York.” The decision, Mr. Catone wrote, was based on the apparent absence of “any therapist-patient relationship between Dr. Leso and any of the Guantánamo detainees” and the OPD’s interpretation of the phrase “modification of behavior for the purpose behavior” in the 2003 statutory definition of the practice of psychology as “referring to behavior undesired by one’s patient, not behavior undesired by third parties.”²²

On August 26, 2010, Dr. Reisner’s attorney requested that OPD reconsider its position, arguing that Dr. Leso’s conduct at Guantánamo fell squarely within the legal definition of psychology in New York. The letter added that Dr. Leso had represented himself as a psychologist, conduct for which New York requires a license.²³ The OPD did not respond to the request for reconsideration.

Legal Challenge:

On November 24, 2010, Dr. Reisner filed a petition in New York district court, requesting that the court invalidate the OPD’s denial and direct the OPD to initiate an investigation into the complaint. He argued that the OPD had erred in its interpretation of the statute, acted arbitrarily and capriciously in dismissing the complaint, and that the OPD had a mandatory duty to investigate allegations of professional misconduct under both New York law and the agency’s own rules and regulations.²⁴ The OPD moved to dismiss, alleging that Dr. Reisner lacked standing to challenge the dismissal because he was not injured by the action and that he had failed to state a cause of action.²⁵

Judge Salliann Scarpulla, of the Supreme Court of New York, heard oral arguments on April 6, 2011.²⁶ New York’s attorney general told the court that Dr. Leso “apparently was asked to use his skills as a weapon, not to help the mental health of the detainees.”²⁷ On August 11, 2011, Judge Scarpulla dismissed Dr. Reisner’s petition on the ground that he had no standing to bring the case. Her decision did not reach the question of whether Dr. Leso’s alleged actions constituted the “practice of psychology” under New York law.²⁸

Complaints Against

Retired Colonel Larry C. James: Louisiana and Ohio

Colonel Larry James, MD, was the senior intelligence psychologist for the Joint Intelligence Group and alleged commander of the Behavioral Science

Consultation Team (BSCT) at the detention center at Guantánamo from January 2003 to May 2003 and June 2007 to May or June 2008.²⁹ He was also director of the Behavioral Science Unit in the Joint Interrogation and Debriefing Center at the Abu Ghraib prison in Iraq from June to October 2004.³⁰ In 2008, he was named dean of the School of Professional Psychology at Wright State University in Dayton, Ohio. At least four professional misconduct complaints were filed against him with psychology boards in two states. Neither board has brought charges.

LOUISIANA STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS

Dr. Trudy Bond v. Dr. Larry James (2008)

Complaint:

On February 29, 2008, Ohio-licensed psychologist Dr. Trudy Bond filed a complaint with the Louisiana State Board of Examiners of Psychologists (LSBEP) requesting that it investigate Dr. James. The complaint included allegations that Dr. James was chief psychologist of the Joint Intelligence Group at Guantánamo at a time when it was camp policy to prevent detainees from having contact with the ICRC and to isolate detainees for 30 days to “enhance and exploit [their] disorientation and disorganization” for interrogation purposes. The complaint alleged that these actions were a violation of American Psychological Association ethics and illegal.³¹

Board Response:

On April 15, 2008, the LSBEP responded with a letter dismissing the complaint, stating that the statute of limitations had run out. The letter further communicated the LSBEP’s consideration of “all allegations of wrongdoing” by Louisiana-licensed psychologists and mentioned that Dr. Bond’s complaint had been reviewed by a complaints coordinator and presented before the board on March 28, 2008.³²

Dr. Bond’s attorney responded to the LSBEP on April 23, 2008, disputing the LSBEP’s interpretation of the statute of limitations. He provided further information on the dates of Dr. James’s alleged conduct as well as the dates of Dr. Bond’s discovery of the alleged conduct.³³ On June 19, 2008, Bond’s legal counsel submitted to the LSBEP additional information that had been publicly revealed since the initial complaint.³⁴ At a second meeting on June 20, 2008, the LSBEP

affirmed its decision not to investigate Dr. James on statute of limitations grounds and communicated this decision to Dr. Bond on June 25, 2008.³⁵

Legal Challenge

On July 22, 2008, Dr. Bond filed a Petition for Judicial Review with the 19th Judicial District Court of the State of Louisiana. The petition alleged that the LSBEP's decision was "clearly contrary to the law," provided no factual basis for its dismissal, and was "arbitrary, capricious and/or characterized by abuse of discretion." Dr. Bond requested that the court either (1) issue a declaratory judgment that her complaint had been timely filed and remand to the LSBEP for an investigation and a hearing or (2) authorize discovery regarding the issue of timeliness.³⁶

The LSBEP filed an answer on August 25, 2008, and later, a motion for peremptory exception of no right of action on May 5, 2009. It denied that its decision was contrary to law, arbitrary, or an abuse of discretion³⁷ and requested that the court dismiss the action. The LSBEP argued that, as an Ohio psychologist, Dr. Bond did not have legal standing to seek judicial review and that she had failed to state a right of action in her petition.³⁸

Following two months of briefing the issues of standing and right of action, Judge R. Michael Caldwell heard oral arguments on July 13, 2009.³⁹ On July 24, 2009, he granted the LSBEP a peremptory exception of no right of action and dismissed the case with prejudice, finding that the "Board's decision not to conduct a hearing into any disciplinary proceedings, whether based on an issue of law or an issue of fact, is not an appealable decision."⁴⁰

Dr. Bond appealed the decision to the Louisiana First Circuit Court of Appeal.⁴¹ Three national organizations—Psychologists for Social Responsibility, Psychoanalysis for Social Responsibility, and Psychologists for an Ethical APA—along with Louisiana-based organizations the Juvenile Justice Project of Louisiana and the Institute of Women and Ethnic studies, filed an amicus brief in support of Dr. Bond's argument that the LSBEP had a "statutory duty to conduct hearings on serious allegations of misconduct by Louisiana psychologists," and that judicial review was required in this case.⁴²

The court concluded that Dr. Bond lacked standing and a right of action to seek judicial review of the dismissal: "...while Dr. Bond may have a professional or ethical duty as a psychologist to file a complaint with the LSBEP about a fellow psychologist's interrogation techniques," Judge Robert Downing wrote, "she, however, has no justiciable right to maintain this action for judicial review."⁴³ Dr. Bond did not appeal this decision.

Neither the 19th District Court nor the First Circuit Court decision commented on the substance of the allegations made against Dr. James in the underlying complaint.

OHIO STATE BOARD OF PSYCHOLOGY

Dr. Trudy Bond v. Dr. Larry James (2008)

Complaint:

Upon learning that Dr. James would seek licensure in Ohio as part of his appointment as dean of the School of Professional Psychology at Wright State, Dr. Bond filed a complaint to the Ohio State Board of Psychology (OSBP) on July 8, 2008, requesting an investigation, evidentiary hearings at which she could present evidence, and the denial of his application. The complaint alleged, among other things, "real, substantial, knowing and ongoing" involvement by Dr. James in the torture of prisoners that rendered him "unfit for licensure" in Ohio and included references to government, media, and American Psychological Association reports. Dr. Bond alleged that Dr. James had violated the Ohio Administrative Code and the American Psychological Association Code of Ethics.⁴⁴

Board Response:

On September 16, 2008, the OSBP responded that it had reviewed the complaint contemporaneously with Dr. James's application for licensure but "determined that no foundation exists to support the initiation of formal proceedings serving to deny Dr. James admission to the Board's licensure examination." The letter provided no further justification for dismissing the complaint.⁴⁵

Dr. Trudy Bond, Mr. Michael Reese, Rev. Colin Bossen, and Dr. Josephine Setzler v. Dr. Larry James (2010)⁴⁶

Complaint:

On July 7, 2010, three additional Ohio residents joined Dr. Bond in filing a new complaint with the OSBP: former U.S. Army Private Michael Reese, Unitarian Universalist minister Rev. Colin Bossen, and Josephine Setzler, executive director of a local affiliate of the National Alliance on Mental Illness. The 2010 complaint contained additional information, some of it drawn from a memoir written by Dr. James and published subsequent to the filing of the 2008 complaint.⁴⁷ The new complaint alleged that Dr. James had (1) demonstrated a lack of good

moral character, (2) exhibited negligence in the practice of psychology, (3) exploited the dependency of his clients and failed to protect them from harm, (4) maintained prohibited “multiple relationships” by assuming conflicting roles in treatment and interrogation that compromised his judgment and objectivity and led to detainee exploitation, (5) failed to maintain confidentiality by instituting a policy that granted BSCT access to medical records of detainees, and (6) misrepresented to the OSBP his experience as a military psychologist and misrepresented to the public his role in detainee abuse. Complainants alleged violations of 18 provisions of laws and rules regulating psychology in Ohio. They requested an investigation into Dr. James’s fitness to practice psychology and ultimately the permanent revocation of his license to practice in the state of Ohio.⁴⁸

Board Response:

In response to complainants’ request, OSBP staff and one board member met with complainants and their counsel on September 30, 2010. Complainants alleged that although the stated purpose of the meeting was to answer legal or factual questions that might concern the OSBP, the OSBP stated that it had no questions and requested to speak with no witnesses.⁴⁹ Almost seven months later, in a letter dated January 26, 2011, the OSBP stated that it had “completed its review” of the complaint, and that “[i]t [had] been determined that [it was] unable to proceed to formal action in this matter.”⁵⁰ No reason was provided.

Legal Challenge:

On April 13, 2011, Dr. Bond, Mr. Reese, Rev. Bossen, and Dr. Setzler filed a petition for a writ of mandamus with the Franklin County Court of Common Pleas in Ohio, asking the court to compel the OSBP to proceed to formal action based on the evidence presented in the complaint, or alternatively, to order the OSBP to investigate meaningfully and in good faith. They requested that the OSBP be required to provide clearly articulated reasons grounded in fact or law for any decision,⁵¹ as well as production of all documents related to the OSBP’s handling of the complaint.⁵² The OSBP moved to dismiss, alleging lack of standing and failure to state a claim and requested a stay on the document production ruling.⁵³ Complainants responded by asserting both private and public interest standing.⁵⁴

On October 24, 2011, Judge Laurel Beatty of the Franklin County Court of Common Pleas referred all pending motions, including requests for discovery and oral argument, to Magistrate Ed Skeens.⁵⁵ On December 16, 2011, Magistrate

Skeens denied both oral argument and discovery and dismissed the mandamus petition. The magistrate concluded that Ohio law did not grant the complainants standing or a right to the relief of mandamus review, and rejected the argument that the OSBP had a legal duty to conduct a good faith investigation and hearing of their complaint.

On December 30, 2011, the complainants filed an objection to the magistrate’s decision, to which the OSBP responded on January 9, 2012. As of December 2012, the case remained pending before Judge Beatty.

Complaint Against James Elmer Mitchell: Texas

A former military psychologist, Dr. James Elmer Mitchell allegedly served as a contract psychologist for the CIA in 2002.

TEXAS STATE BOARD
OF EXAMINERS OF PSYCHOLOGISTS
Dr. Jim Cox v. Dr. James Mitchell (2010)

Complaint:

On June 17, 2010, Texas psychologist Dr. Jim Cox filed a complaint with the Texas State Board of Examiners of Psychologists (TSBEP), alleging that Dr. Mitchell had been one of the primary architects of the CIA’s torture techniques and that he had allegedly enabled and personally participated in the torture of a detainee known as Abu Zubaydah. The complaint alleged that Dr. Mitchell (1) misrepresented his professional qualifications and experience to the CIA, (2) failed to take reasonable steps to ensure the safety of others in the design of the interrogation regime and therefore acted without a scientific basis, and (3) violated his professional duty to persons in his care by torturing prisoners held in U.S. custody himself and directly supervising others who engaged in torture at his direction. The complaint alleged violations of 11 provisions of the Psychologists Licensing Act and the rules promulgated by the board under the act, including norms governing competency; professional objectivity; improper sexual conduct; and evaluation, assessment, and testing of a human subject without informed consent.⁵⁶ Dr. Cox requested review of the matter and appropriate action.

The American Psychological Association submitted a letter to the TSBEP saying “[i]f any psychologist member of APA were proven to have committed the alleged acts as set forth in the Complaint before the Board, he or she would be expelled from the APA membership. The relevant state licensing board(s) would be notified of this APA action, and it would be our expectation that the individ-

ual's state license to practice psychology would be revoked."⁵⁷ Dr. Mitchell is not a member of the American Psychological Association.

Board Response:

On February 8, 2011, the TSBEP held an informal settlement conference in which a three-member disciplinary review panel received evidence and heard from both parties at separate times, in ex-parte confidential proceedings. Following a meeting on February 10, 2011, the TSBEP dismissed Dr. Cox's complaint against Dr. Mitchell, citing insufficient evidence of a violation.⁵⁸

Legal Challenge:

On October 17, 2011, Dr. Cox filed a request for declaratory judgment under Texas law that Dr. Mitchell's conduct was contrary to the TSBEP rules, and that if his conduct was not contrary to the rules, that those rules are invalid. The request cited Dr. Mitchell and the TSBEP as defendants and included supporting declarations from psychologists Michael Wessell and Stephen Soldz. A hearing was scheduled for December 8, 2011.⁵⁹ The trial court dismissed the complaint for lack of standing.⁶⁰

*Complaint Against
Lieutenant Colonel Diane Michelle Zierhoffer: Alabama*

Dr. Diane Michelle Zierhoffer was a Lt. Col. in the U.S. Army who allegedly served as a BSCT psychologist at Guantanamo.

ALABAMA BOARD

OF EXAMINERS IN PSYCHOLOGY

Dr. Trudy Bond v. Dr. Diane Zierhoffer (2008)

Complaint:

On November 21, 2008, Dr. Trudy Bond filed a complaint with the Alabama Board of Examiners in Psychology (ABEP) against Dr. Diane Zierhoffer. The complaint alleged that Dr. Zierhoffer was called to do a mental assessment of an adolescent detainee, Mohammed Jawad, whose behavior had given an interrogator cause for concern about his mental health, and that in response, she had concluded that he was "faking homesickness, sadness and depression as a resist-

ance technique and recommended that he be placed in physical and linguistic isolation to increase his discomfort as a way to induce his cooperation." Dr. Bond quoted a report allegedly prepared by Dr. Zierhoffer as saying: "He appears to be rather frightened, and it looks as if he could break easily if he were isolated from his support network and made to rely solely on the interrogator... Make him as uncomfortable as possible. Work him as hard as possible." The complaint alleged that Dr. Zierhoffer recommended that Jawad be sent to isolation for another 30 days, moved to a section of the prison where he would be the only Pashto speaker, and be made to believe that his family had forgotten him. Dr. Bond alleged that these actions led to the deterioration of Jawad's mental health and culminated in a suicide attempt.⁶¹

Board Response:

Less than a month later, on December 18, 2008, ABEP denied Dr. Bond's "request for [the Board] to accept jurisdiction over [her] complaint," stating that it had given "careful consideration and extensive research into the feasibility of the Board's investigation of the issues raised in the complaint."⁶² On February 17, 2009, Terry Lodge, counsel for Dr. Bond, responded to the ABEP's determination, arguing that the ABEP had failed to follow investigative procedures in response to Dr. Bond's complaint, as required under the Alabama Administrative Code.⁶³ The board has not responded to Mr. Lodge's request that the board follow the administrative code procedures.

On April 1, 2009, Dr. Bond filed a supplement that added the declaration of Lieutenant Colonel Darrel Vandeveld, U.S. Army Reserve JAG Corps, to her original complaint. Lt. Col. vandeveld was the lead prosecutor in the military commission case against Mohammed Jawad. In his declaration, vandeveld described his experience with Jawad's case and his impression that, in her alleged function as a BSCT psychologist, Dr. Zierhoffer "employed [her] professional training and expertise in a profoundly unethical manner."⁶⁴ As of December 2012, the board had not responded to the February 2009 letter or the April 2009 supplement.

Notes

EXECUTIVE SUMMARY

- 1 There are many accounts of the genesis of the new policy and their legality. Some include Jane Mayer, *The Dark Side* (2009) and Philippe Sands, *Torture Team* (2007). Additional references are in chapter 1.
- 2 Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006); Physicians for Human Rights, *Break Them Down: The Use of Psychological Torture against Detainees in US Custody* (Cambridge, MA: Physicians for Human Rights, 2005).
- 3 Central Intelligence Agency, Career Opportunities, “Medical Officer,” <https://www.cia.gov/careers/opportunities/support-professional/medical-officer.html>.
- 4 Central Intelligence Agency, Office of Medical Services, “OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation, and Detention” (May 2004), 8, n. 2, <http://www.aclu.org/torturefoia/released/103009/cia-ole/2.pdf>. Two other versions of this document that have been released, one from September 2003 and another from December 2004, are identical in this respect.
- 5 Many of the relevant documents in the period 2002-2005, released through 2006, are collected in Jaffer and Singh, *The Administration of Torture* (2007). Many of the legal memos are collected in David Cole, *The Torture Memos* (2009).
- 6 See, e.g., Fletcher and Stover, *The Guantanamo Effect* (2009). Additional references are in chapter 1.
- 7 Alfred W. McCoy, *A Question of Torture: CIA Interrogation, From the Cold War to the War on Terror* (New York: Metropolitan Books, 2006).
- 8 OMS Guidelines (May 2004).
- 9 U.S. Senate Committee on Armed Services, *Inquiry into the Treatment of Detainees in U.S. Custody*, 110th Cong., 2d sess. (2008), http://www.armed-services.senate.gov/Publications/Detainee%20Report%20Final_April%2022%202009.pdf.
- 10 U.S. Department of Justice, Office of Legal Counsel, “Memorandum for John Rizzo, Acting General Counsel of the Central Intelligence Agency: Interrogation of al Qaeda Operative” (August 2002), 4, http://dspace.wrlc.org/doc/bitstream/2041/70967/00355_020801_004display.pdf.
- 11 OMS Guidelines (May 2004).

- 12 U.S. Department of Justice, Office of Legal Counsel, "Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques That May Be Used in the Interrogation of a High Value al Qaeda Detainee" (May 2005), <http://www.fas.org/irp/agency/doj/olc/techniques.pdf>.
- 13 The planning and implementation of this interrogation is reviewed in U.S. Senate Committee on Armed Services, *Inquiry into the Treatment of Detainees in U.S. Custody* (2008). See chapter 1 for additional references.
- 14 Physicians for Human Rights, *Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and Its Impact* (Cambridge, MA: Physicians for Human Rights, 2008).
- 15 U.S. Department of the Army, Office of the Surgeon General, *Final Report: Assessment of Detainee Medical Operations for OEF, GTMO, and OIF* (2005), http://www.globalsecurity.org/military/library/report/2005/detmedopsrpt_13apr2005.pdf.
- 16 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006), <http://www.dtic.mil/whs/directives/corres/pdf/231008p.pdf>.

INTRODUCTION

- 1 U.S. National Institutes of Health, Office of History, "Nuremberg Code" (1947), <http://history.nih.gov/research/downloads/nuremberg.pdf>.
- 2 UN General Assembly, Resolution 217 A (III), *Universal Declaration of Human Rights* (10 December 1948), <http://www.unhcr.org/refworld/docid/3ae6b3712c.html>.
- 3 International Committee of the Red Cross, *Geneva Convention Relative to the Treatment of Prisoners of War (Third Geneva Convention)* (12 August 1949), 75 UNTS 135, <http://www.unhcr.org/refworld/docid/3ae6b36c8.html>.
- 4 Philip Spoerri, "The Geneva Conventions of 1949: Origins and Current Significance" (Address, International Committee of the Red Cross ceremony to celebrate the 60th anniversary of the Geneva Conventions, 12 August 2009), www.icrc.org/web/eng/siteeng0.nsf/html/geneva-conventions-statement-120809.
- 5 International Committee of the Red Cross, "Commentary - Art. 130. Part VI," *Geneva Convention (III) relative to the Treatment of Prisoners of War* (12 August 1949), <http://www.icrc.org/ihl.nsf/COM/375-590156?OpenDocument>.
- 6 Darius Rejali, *Torture and Democracy* (Princeton: Princeton University Press, 2007), 399.
- 7 World Medical Association, *Declaration of Tokyo* (1975; revised May 2006), www.wma.net/en/30publications/10policies/c18/index.html.
- 8 UN General Assembly, *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: resolution / adopted by the General Assembly* (1984), <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx>.
- 9 "Definitions," *U.S. Code* 18 (1994), § 2340, <http://www.law.cornell.edu/uscode/text/18/2340>.
- 10 Central Intelligence Agency, Career Opportunities, "Medical Officer," <https://www.cia.gov/careers/opportunities/support-professional/medical-officer.html>.

- 11 Central Intelligence Agency, Office of Medical Services, "OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation, and Detention" (May 2004), 8, n. 2, <http://www.aclu.org/torturefoia/released/103009/cia-olc/2.pdf>. Two other versions of this document that have been released, one from September 2003 and another from December 2004, are identical in this respect.

CHAPTER 1

- 1 Laurel E. Fletcher and Eric Stover, *The Guantanamo Effect: Exposing the Consequences of U.S. Detention and Interrogation Practices* (Berkeley and Los Angeles: University of California Press, 2009).
- 2 Jane Mayer, *The Dark Side: The Inside Story of How the War on Terror Turned Into a War on American Ideals* (New York: Anchor Books, 2009).
- 3 Ibid.
- 4 Ibid., 43.
- 5 U.S. Department of Justice, Office of Legal Counsel, "Memorandum for John A. Rizzo, Acting General Counsel, Central Intelligence Agency, Re: Application of the War Crimes Act, the Detainee Treatment Act, and Common Article 3 of the Geneva Conventions to Certain Techniques that May Be Used by the CIA in the Interrogation of High Value al Qaeda Detainees" (20 July 2007), <http://www.justice.gov/olc/docs/memo-warcrimesact.pdf> [hereafter cited as OLC 2007].
- 6 Jane Mayer, *The Dark Side* (2009); U.S. Senate Committee on Armed Services, *Inquiry into the Treatment of Detainees in U.S. Custody* (2008); Joseph Margulies, *Guantanamo and the Abuse of Presidential Power* (2008); Fletcher and Stover, *The Guantanamo Effect* (2009); International Committee of the Red Cross, *ICRC Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody* (2007); Physicians for Human Rights, *Break Them Down* (2005); Neil Lewis, "Red Cross Finds Detainee Abuse in Guantanamo," *New York Times* (30 November 2004). Many key documents in the public record, almost all from the U.S. military and some from the Justice Department, are contained in Jaffer and Singh, *Administration of Torture* (2006). Certain CIA documents and Justice Department opinions were released by the Obama administration in 2009.
- 7 UN General Assembly, *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: resolution / adopted by the General Assembly* (1984), <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx>; "Definitions," *U.S. Code* 18 (1994), § 2340.
- 8 Tom Malinowski, "Banned State Department Practices," in *Torture: Does it Work? Is It Ever OK? A Human Rights Perspective*, ed. Kenneth Roth and Minky Worden (New York: The New Press, 2005).
- 9 Physicians for Human Rights and Human Rights First, *Leave No Marks: Enhanced Interrogation and the Risk of Criminality* (Physicians for Human Rights and Human Rights First, 2007); Darius Rejali, *Torture and Democracy* (2007); Philippe Sands, *Torture Team* (2007).
- 10 Jane Mayer, *The Dark Side* (2009) [see note 2].
- 11 Jane Mayer, *The Dark Side* (2009); Steven Miles, *Oath Betrayed* (2006); Steven Miles, "Medical Ethics and the Interrogation of Guantanamo 063," *American Journal of Bioethics* 7, no. 5 (2007): 1-7; Bloche and Marks, "Doctors and Interrogators at Guantanamo Bay," *New England Journal of Medicine* 353 (2005); Leonard S. Rubenstein, "First, Do No Harm: Health Professionals and

- Guantanamo Bay,” *Seton Hall Law Review* 37 (2007): 733-748; *Physicians for Human Rights, Break Them Down* (2005); Rubenstein and Xenakis, “Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees,” *JAMA* 304, no. 5 (2010): 569-570.
- 12 The Task Force has no knowledge of whether detainees in CIA custody engaged in hunger strikes, and if so, what role, if any, health professionals played in seeking to break them. Nor does the Task Force have any knowledge whether health professionals participated in setting the conditions of confinement for detainees in CIA custody.
- 13 In 2002, the U.S. Justice Department issued legal opinions interpreting the U.S. anti-torture statute and the inherent power of the president to allow techniques of interrogation, including waterboarding, stress positions, exposure to extreme temperatures, confinement in a small box, and others. The opinions included extremely constricted interpretations of the meaning of the key phrase “severe physical or mental pain or suffering,” so as to exclude most practices. These interpretations also required that the alleged perpetrator specifically intend to cause such pain. David Luban, “Liberalism, Torture and the Ticking Bomb,” in *The Torture Debate in America*, ed. Karen Greenberg (New York: Cambridge University Press, 2006). Later opinions from the Justice Department relied far more heavily on medical input. U.S. Department of Justice, office of Legal Counsel, “Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques That May Be Used in the Interrogation of a High Value al Qaeda Detainee” (May 2005). Contrary to international and domestic consensus on the scope of international legal obligations, the Bush administration also took the position that the prohibition on cruel, inhuman, or degrading treatment did not apply to the CIA.
- 14 The role of physicians in supervising individuals who are not physicians is important for understanding the overall responsibility of physicians for acts relating to detainees in the past, but also prospectively, since medics and corpsmen are capable of performing many of the functions of physicians and should be considered in attempts to prevent medical misconduct in the future. The Task Force understands that physicians have played a role in reviewing the performance of medics and corpsmen, but does not have information about the precise supervisory role at Guantanamo and other places of detention.
- 15 *Hamdan v. Rumsfeld*, 548 U.S. 557 (2006).
- 16 U.S. Department of the Army, Headquarters, FM 2-22.3 (FM 34-52), *Human Intelligence Collector Operations* (September 2006), <http://scip.cms-plus.com/files/Resources/Army-Human-Intelligence-Collector.pdf>.
- 17 U.S. Department of Defense, Directive 3115.09, “DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning” (2008; revised October 2012), Enclosure 3, <http://www.dtic.mil/whs/directives/corres/pdf/311509p.pdf>.
- 18 *Ibid.*
- 19 OLC 2007.
- 20 Executive Order no. 13491, “Ensuring Lawful Interrogations,” *U.S. Code of Federal Regulations* (22 January 2009), title 3, http://www.whitehouse.gov/the_press_office/EnsuringLawfulInterrogations.
- 21 Admiral Patrick Walsh, U.S. Department of Defense, *Review of Department Compliance with President’s Executive Order on Detainee Conditions of Confinement* (2009), 52, http://www.defense.gov/pubs/pdfs/review_of_department_compliance_with_presidents_executive_order_on_detainee_conditions_of_confinementa.pdf. Nongovernmental organizations, however, have reported ongoing abuses, including solitary confinement for the majority of detainees, continued use of sensory deprivation and environmental manipulation, physical assault on detainees by the prison’s Immediate Reaction Force, denial of independent medical evaluations, continued use of force-feeding, and severe limitations on communications with the outside world. Center for Constitutional Rights, *Current Conditions of Confinement at Guantanamo* (New York: Center for Constitutional Rights, 23 February 2009), http://ccrjustice.org/files/CCR_Report_Conditions_At_Guantanamo.pdf.
- 22 OLC 2007.
- 23 Katherine Shrader, Associated Press, “U.S. Has Detained 83,000 in War on Terror,” *Washington Post* (16 November 2005), http://www.washingtonpost.com/wp-dyn/content/article/2005/11/16/AR2005111601475_pf.html.
- 24 Scott Allen and others, “Deaths of Detainees in Custody of US Forces in Iraq and Afghanistan from 2002-2005,” *MedGenMed* 8, no. 4 (2006): 46.
- 25 Fletcher and Stover, *The Guantanamo Effect* (2009); Tom Lasseter, “U.S. Abuse of Detainees Was Routine in Afghanistan Bases,” *McClatchy Newspapers* (17 June 2008), <http://www.mcclatchydc.com/2008/06/16/38775/day-2-us-abuse-of-detainees-was.html>.
- 26 Major General George R. Fay, “AR 15-6 Investigation of the Abu Ghraib Detention Facility and 205th Military Intelligence Brigade” (2004), 41, <http://f1.findlaw.com/news.findlaw.com/hdocs/docs/DoD/fay82504rpt.pdf>; Fletcher and Stover, *The Guantanamo Effect* (2009); *Physicians for Human Rights, Broken Laws, Broken Lives* (2008); Tom Lasseter, “U.S. Abuse of Detainees Was Routine in Afghanistan Bases,” *McClatchy Newspapers* (17 June 2008); Tim Golden, “In U.S. Report, Brutal Details of 2 Afghan Inmates’ Deaths,” *New York Times* (20 May 2005), <http://www.nytimes.com/2005/05/20/international/asia/20abuse.html?pagewanted=all/>.
- 27 U.S. Department of Defense, Office of the Secretary of Defense, *Review of Defense Detention Operations and Detainee Interrogation Techniques*, by Admiral A.T. Church (2006), http://www.aclu.org/images/torture/asset_upload_file625_26068.pdf (redacted version) and http://www.aclu.org/files/pdfs/safefree/church_353365_20080430.pdf (pages that were originally redacted); Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006).
- 28 *Physicians for Human Rights, Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and Its Impact* (Cambridge, MA: Physicians for Human Rights, 2008); Laurel E. Fletcher and Eric Stover, *Guantanamo and Its Aftermath* (Berkeley: Human Rights Center and International Human Rights Law Clinic, University of California, 2008).
- 29 U.S. Department of the Army, Office of the Surgeon General, *Final Report: Assessment of Detainee Medical Operations for OEF, GTMO, and OIF* (2005), http://www.globalsecurity.org/military/library/report/2005/detmedopsrpt_13apr2005.pdf [hereafter cited as Surgeon General Report (2005)].
- 30 *Physicians for Human Rights, Broken Laws, Broken Lives* (2008); Fletcher and Stover, *The Guantanamo Effect* (2009).
- 31 Surgeon General Report (2005).
- 32 Jane Mayer, *The Dark Side*, (2009), 142 [see note 2].
- 33 *Ibid.*, p 156.

- 34 Alfred W. McCoy, *A Question of Torture: CIA Interrogation, From the Cold War to the War on Terror* (New York: Metropolitan Books, 2006).
- 35 Central Intelligence Agency, "Background Paper on CIA's Combined Used of Interrogation Techniques" (2004), 1, <http://www.adu.org/torturefoia/released/082409/olcremand/2004olc97.pdf>. "Learned helplessness" was an apparent reference to the work of psychologist Martin Seligman, starting in the 1960s, concerning how the imposition of various forms of pain could lead to passivity in the face of the infliction of additional pain. In 2002 seligman briefed CIA and SERE personnel on the theory. Jane Mayer, *The Dark Side* (2009), 163-64 [see note 2].
- 36 Central Intelligence Agency, Office of Medical Services, "OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation, and Detention" (May 2004), <http://www.aclu.org/torturefoia/released/103009/cia-olc/2.pdf>; Alfred W. McCoy, *A Question of Torture* (2006).
- 37 OLC 2007, 6.
- 38 Alfred W. McCoy, *A Question of Torture* (2006).
- 39 Central Intelligence Agency, KUBARK Counterintelligence Interrogation (1963), <http://www.scribd.com/doc/487663/CIAKubarkTorture-Manual> and <http://www.scribd.com/doc/43673248/1963-CIA-KUBARK-Interrogation-Manual-Part-2>.
- 40 Central Intelligence Agency, Human Resource Exploitation Training Manual (1983), <http://www.gwu.edu/~nsarchiv/NSAEBB/NSAEBB27/02-01.htm> (excerpt); Alfred W. McCoy, *A Question of Torture* (2006).
- 41 U.S. Senate Committee on Armed Services, *Inquiry into the Treatment of Detainees in U.S. Custody*, 110 th Cong., 2d sess. (2008), http://www.armed-services.senate.gov/Publications/Detainee%20Report%20Final_April%2022%202009.pdf [hereafter cited as Senate Armed Services Report (2008)].
- 42 U.S. Department of the Army, Headquarters, U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 06-029, "Behavioral Science Consultation Policy" (2006), <http://archives.lwisc.edu/us-gitmo-bsct-policy-2006-2008.pdf>.
- 43 Senate Armed Services Report (2008); Jane Mayer, *The Dark Side* (2009); Katherine Eban, "Rorschach and Awe," *Vanity Fair* (online) (17 July 2007), <http://www.vanityfair.com/politics/features/2007/07/torture200707?printable=true¤tPage=all>.
- 44 U.S. Department of Justice, Office of Legal Counsel, "Memorandum for John Rizzo, Acting General Counsel of the Central Intelligence Agency: Interrogation of al Qaeda Operative" (August 2002), <http://www.fas.org/irp/agency/doj/olc/zubaydah.pdf> [hereafter cited as OLC Zubaydah].
- 45 The placement of an insect in a box was not employed and the technique does not appear in later lists of enhanced interrogation methods.
- 46 U.S. Department of Justice, Office of Legal Counsel, "Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques That May Be Used in the Interrogation of a High Value al Qaeda Detainee" (May 2005), 7, <http://www.fas.org/irp/agency/doj/olc/techniques.pdf> [hereafter cited as OLC 2005].
- 47 Ibid., 8.
- 48 Ibid.
- 49 Ibid.
- 50 Ibid., 9.
- 51 Ibid.
- 52 Ibid., 11.
- 53 Ibid., 14.
- 54 Ibid., 1.
- 55 Ibid., 18.
- 56 Senate Armed Services Report (2008).
- 57 The studies on the medical and psychological impact of these techniques is summarized in Physicians for Human Rights and Human Rights First, *Leave No Marks* (2007) and K. Alexa Koenig, Eric Stover, and Lauren E. Fletcher, "The Cumulative Effect: A medico-legal approach to United States torture law and policy," *Essex Human Rights Review* 6, no. 1 (2009): 145-167. Regarding the scientific basis of CIA assessments, see vincent Iacopino, Scott Allen, and Allen Keller, "Bad Science Used to Support Torture and Human Experimentation," *Science* 331 (2011): 34-35.
- 58 Physicians for Human Rights and Human Rights First, *Leave No Marks* (2007); K. Alexa Koenig, Eric Stover, and Lauren E. Fletcher, "The Cumulative Effect: A medico-legal approach to United States torture law and policy," *Essex Human Rights Review* 6, no. 1 (2009): 145-167.
- 59 OLC Zubaydah.
- 60 Ibid., 17.
- 61 The close collaboration between the psychologists and the Office of Legal Counsel is revealed in the note accompanying the psychological assessment: "Here is the psychological assessment. Please feel to call me at work or at home, whenever. Thanks." Central Intelligence Agency, Office of Legal Counsel, Zubaydah psychological assessment (24 July 2002), <http://www.aclu.org/torturefoia/released/082409/olcremand/2004olc4.pdf>.
- 62 OLC Zubaydah.
- 63 Ibid., 4.
- 64 International Committee of the Red Cross, *ICRC Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody* (2007), 21-22, <http://www.nybooks.com/media/doc/2010/04/22/icrc-report.pdf> [hereafter cited as ICRC Report (2007)]. The detainees told the ICRC that they could not identify the profession of the individuals but presumed they were physicians or psychologists.
- 65 Ibid., 21.
- 66 Ibid., 22.
- 67 As the ICRC noted in its report, the detainees have had no opportunity to communicate with one another since being taken into custody, so the accounts could not have been coordinated.
- 68 ICRC Report (2007), 22.
- 69 Ibid., 21-22.

- 70 ICRC Report (2007), 9, citing U.S. Department of Justice, Office of Legal Counsel, "Memorandum for Alberto R. Gonzales, Counsel to the President, Re: Standards of Conduct for Interrogation under 18 U.S.C. §§ 2340-2340A, (1 August 2002), <http://f1.findlaw.com/news.findlaw.com/wp/docs/doj/bybee80102mem.pdf> (stating that "severe" means a level of pain associated with a serious physical condition or injury such as death, organ failure, or serious impairment of body function). Examples of acts the Office of Legal Counsel considered "severe" included severe beatings with clubs and burning of prisoners. OLC Zubaydah, 10.
- 71 The U.S. criminal statute on torture also contains a specific definition of severe mental pain or suffering as "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." "Definitions," *U.S. Code* 18 (1994), § 2340. The Justice Department argued in its opinions that the requirement of prolonged harm "result in significant psychological harm of significant duration," and that none of the enhanced methods had such results, e.g., "lasting for months or even years." U.S. Department of Justice, Office of Legal Counsel, "Memorandum for Alberto R. Gonzales, Counsel to the President, Re: Standards of Conduct for Interrogation under 18 U.S.C. §§ 2340-2340A," (1 August 2002), <http://f1.findlaw.com/news.findlaw.com/wp/docs/doj/bybee80102mem.pdf>. This reading of the statute conflicts with the specific enumeration of the four types of harm deemed by Congress to result in such prolonged harm, as well the legislative history of the law. See Physicians for Human Rights, *Break Them Down* (2009), 78-79.
- 72 American Medical Association, "Principles of Medical Ethics VIII" (Chicago: American Medical Association, 1957; revised 2001), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>. The American College of Physicians specifically addressed the obligation somewhat differently: "Under no circumstances is it ethical for a physician to be used as an instrument of government for the purpose of weakening the physical or mental resistance of another human being." "American College of Physicians Ethics Manual, Third Edition," *Annals of Internal Medicine* 117, no. 11 (1 December 1992): 947-60, <http://www.ncbi.nlm.nih.gov/pubmed/1443957>. Although there may be ambiguity as to whether a detainee not under a physician's care, e.g., a person to be interrogated, is a patient, the AMA and other medical associations' ethical guidance regarding participation in interrogation makes no distinction with respect to the duty of beneficence.
- 73 American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, Standard 3.04, "Avoiding Harm" (2002), <http://www.apa.org/ethics/code/index.aspx?item=6>.
- 74 As stated earlier, we use the term medical personnel when the occupation of the individual, e.g., doctor, nurse, medic, is not specified. In cases where documents indicate that a physician or nurse was involved in a particular activity or provided an opinion to the Department of Justice, we so indicate.
- 75 Central Intelligence Agency, Office of the Inspector General, *Special Review: Counterterrorism Detention and Interrogation Activities (September 2001-October 2003)* (7 May 2004), 1-2, http://media.luxmedia.com/aclu/IG_Report.pdf.
- 76 *Ibid.*, 21, n. 26.
- 77 *Ibid.*
- 78 Central Intelligence Agency, Office of the Inspector General, Appendix F to Inspector General Report 2004 [see note 75], "Draft Office of Medical Services Guidelines on Medical and Psychological Support to Detainee Interrogations" (September 2003), 2, <http://graphics8.nytimes.com/packages/pdf/politics/20090825-DETAIN/2004CIAIG.pdf>. At least two versions of the guidelines were issued in 2004, one in May (<http://www.aclu.org/torturefoia/released/103009/cia-olc/2.pdf>) and one in December. The Task Force does not know how long the guidelines remained in effect.
- 79 OLC Zubaydah, 4.
- 80 OMS Guidelines (May 2004), Appendix A [see note 36]; OLC 2005 [see note 46]. The Office of Medical Services also collected data on the impact of some of the techniques used. Physicians for Human Rights, *Experiments in Torture: Evidence of Human Subject Research and Experiments in the "Enhance" Interrogation Program* (Cambridge, MA: Physicians for Human Rights, 2010), <http://phrtorturepapers.org/>.
- 81 OMS Guidelines (May 2004).
- 82 U.S. Department of Justice, Office of Legal Counsel, "Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, Re: Application of 18 U.S.C. §§2340-2340A to the Combined Use of Certain Techniques in the Interrogation of High Value al Qaeda Detainees" (May 2005), 62, <http://www.fas.org/irp/agency/doj/olc/combined.pdf>.
- 83 OLC 2005 [see note 46].
- 84 OLC 2007, 9 [see note 5].
- 85 *Ibid.*, 9, n. 9.
- 86 Leonard S. Rubenstein and Stephen N. Xenakis, "Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees," *JAMA* 304, no. 5 (2010): 569-570.
- 87 OLC 2005, 39.
- 88 *Ibid.*, 42.
- 89 Jonathan Beynon, "'Not waving, drowning': Asphyxia and torture: the myth of simulated drowning and other forms of torture," *Torture* 22, Suppl. No. 1 (2012): 25-29.
- 90 U.S. Department of Justice, Office of Legal Counsel, "Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, Re: Application of 18 U.S.C. §§2340-2340A to the Combined Use of Certain Techniques in the Interrogation of High Value al Qaeda Detainees" (May 2005), 12, <http://www.sfas.org/irp/agency/doj/olc/combined.pdf>.
- 91 The chart is reproduced in Rubenstein and Xenakis, "Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees," *JAMA* 304, no. 5 (2010): 569-570.
- 92 Physicians for Human Rights and Human Rights First, *Leave No Marks* (2007).
- 93 Physicians for Human Rights, *Experiments in Torture* (2010).
- 94 OLC 2007, 5.
- 95 ICRC Report (2007), 26 [see note 64].
- 96 Karen Greenberg, *The Least Worst Place: Guantanamo's First 100 Days* (New York: Oxford University Press USA, 2009), 150-158.
- 97 *Ibid.*, 161.

- 98 U.S. Department of Defense, Directive 3115.13, "DoD Support to the High-Value Detainee Interrogation Group" (2010), <http://www.dtic.mil/wbs/directives/corres/pdf/311513p.pdf>.
- 99 Senate Armed Services Report (2008) [see note 41].
- 100 Ibid.
- 101 U.S. Department of Defense, JTF GTMO, "BSCT Standard Operation Procedures" (11 November 2002), <http://www.aclu.org/files/projects/foiasearch/pdf/DODDON000760.pdf> (last document in packet). The composition of the BSCTs varied over time. In late 2004, a Joint Intelligence Group memorandum specified that a BSCT would be composed of two clinical psychologists and a mental health specialist. U.S. Department of Defense, JTF GTMO, "Operational Policy Memorandum #14, Behavioral Science Consultation Team" (10 December 2004), <http://www.aclu.org/files/projects/foiasearch/pdf/DODDON000760.pdf> (second document in packet).
- 102 Senate Armed Services Report (2008), 52.
- 103 Ibid., 50.
- 104 Ibid., 51-52.
- 105 Ibid., 52, quoting Paul Burney and [classified], Memorandum for the Record, October 2, 2002.
- 106 Ibid., 67-69.
- 107 Senate Armed Services Report (2008).
- 108 U.S. Department of Defense, "JTF GTMO SERE Interrogation Standard Operating Procedure" (December 2002), <http://www.torturingdemocracy.org/documents/20021210.pdf>.
- 109 Ibid.
- 110 Senate Armed Services Report (2008), 60.
- 111 Ibid., 74-83.
- 112 Ibid.
- 113 Ibid., 81-82.
- 114 Ibid., 88.
- 115 Ibid., 88-91. See also Philippe Sands, *Torture Team* (2007).
- 116 U.S. Department of Defense, Sworn Statement by [redacted], AR 15-6 GTMO Investigation (11 January 2005), http://www.DoD.mil/pubs/foi/operation_and_plans/Detainee/Exhibit_63_to_AR15_6GTMO_Investigation.pdf.
- 117 Senate Armed Services Report (2008), 91.
- 118 U.S. Department of Defense, Sworn Statement by [redacted], AR 15-6 GTMO Investigation (11 January 2005), http://www.DoD.mil/pubs/foi/operation_and_plans/Detainee/Exhibit_63_to_AR15_6GTMO_Investigation.pdf.
- 119 Physicians for Human Rights, *Break Them Down: The Use of Psychological Torture against Detainees in US Custody* (Cambridge, MA: Physicians for Human Rights, 2005).
- 120 Surgeon General Report (2005), 19-7 [see note 29].
- 121 Ibid.
- 122 U.S. Department of Defense, Joint Task Force - Guantanamo, Headquarters, "Camp Delta Standard Operating Procedures" (28 March 2003), 4.3, <http://www.comw.org/warreport/fulltext/gitmo-sop.pdf>.
- 123 Neil Lewis, "Red Cross Finds Detainee Abuse in Guantanamo," *New York Times* (30 November 2004), <http://www.nytimes.com/2004/11/30/politics/30gitmo.html>.
- 124 M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *New England Journal of Medicine* 352, no. 1 (2005): 3-6.
- 125 U.S. Department of Defense, Assistant Secretary of Defense Memorandum, "Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States," (3 June 2005), <http://www1.umn.edu/humanrts/OathBetrayed/Winkenwerder%206-3-2005.pdf>.
- 126 U.S. Department of Defense, Directive 3115.09, "DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning," (November 2005), <http://www1.umn.edu/humanrts/OathBetrayed/Interrogation%20Directive%203115.09.pdf>. This directive was revised in 2008 (http://www.fas.org/irp/DoDdir/DoD/d3115_09.pdf).
- 127 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006), <http://www.dtic.mil/wbs/directives/corres/pdf/231008p.pdf>.
- 128 Ibid.
- 129 Ibid.
- 130 Ibid.
- 131 U.S. Department of Defense, Joint Task Force - Guantanamo, Memorandum for Maj. General Geoffrey D. Miller, "Results of Commander's Inquiry, Re: Allegation of Inhumane Treatment of [redacted]" (30 April 2003), 1318-1322 and 1360-1364.
- 132 *United States v. Jawad*, 1 M.C. 334 (2008).
- 133 Declaration of Darrel vandevelde in "Amended Petition for Writ of Habeas Corpus on Behalf of Mohammed Jawad (also known as Saki Bacha)," In Re: Guantanamo Bay Detainee Litigation, *Al Hamandy v. Bush*, No. 05-cv-2385 (RMU) (D.D.C. 2009), Exhibit B, para. 23.
- 134 Senate Armed Services Report (2008), 140-141. The interrogation is described at pages 136-40 [see note 41].
- 135 Senate Armed Services Report (2008), 50.
- 136 Ibid., 57.
- 137 Larry C. James, *Fixing Hell: An Army Psychologist Confronts Abu Ghraib* (Grand Central Publishing, 2008), 29.
- 138 U.S. Department of Defense, Office of the Secretary of Defense, *Review of Defense Detention Operations and Detainee Interrogation Techniques*, by Admiral A.T. Church (2006), 355, http://www.aclu.org/files/pdfs/safefree/church_353365_20080430.pdf [hereafter cited as Church Report (2006)]. Many of the extensive findings on medical care and medical involvement in interrogation in Admiral Church's report, which is the only internal report

- that extensively reviews the conduct of medical personnel regarding detainees, were redacted in the original publicly released version. Subsequently, pages referring to medical care with fewer redactions were released. The surgeon general's report, by contrast, was not redacted, but it is based on a survey rather than an investigation.
- 139 Surgeon General Report (2005), 18-14 [see note 29].
- 140 U.S. Department of the Army, Headquarters, FM 2-22.3 (FM 34-52), *Human Intelligence Collector Operations* (September 2006), <http://scip.cms-plus.com/files/Resources/Army-Human-Intelligence-Collector.pdf>; U.S. Department of Defense, Directive 3115.09, "DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning" (2008; revised October 2012).
- 141 U.S. Department of the Army, Headquarters, U.S. Army Medical command, oTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning" (2009), 15; U.S. Department of the Army, Headquarters, U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 16.
- 142 OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 7.
- 143 *Ibid.*, 13.
- 144 *Ibid.*
- 145 *Ibid.*, 6.
- 146 *Ibid.*, 13.
- 147 U.S. Department of Defense, Directive 3115.09, "DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning" (2008; revised October 2012).
- 148 Surgeon General Report (2005) [see note 29].
- 149 Surgeon General Report (2005).
- 150 Church Report (2006), 354.
- 151 Surgeon General Report (2005). The survey included 1,182 currently deployed, previously deployed, and to-be-deployed medical personnel from 180 units in Afghanistan, Iraq, and at Guantanamo Bay. Of those surveyed, 993 were interviewed, 52.7% of whom were officers and 47% enlisted. Seven individuals assigned to Guantanamo BSCTs were interviewed, as were four in Iraq. The team was led by Major General Lester Martinez-Lopez, then commanding general of the U.S. Army Medical Research and Materiel Command.
- 152 Church Report (2006), 354.
- 153 Surgeon General Report (2005), 7-2.
- 154 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005), 1-9, <http://www.globalsecurity.org/military/library/policy/army/other/st4-02-46.pdf>.
- 155 Surgeon General Report (2005), appendix; Church Report (2006), 354; Steven Miles, *Oath Betrayed* (2006), chap. 5 [see note 27].
- 156 Surgeon General Report (2005); Fletcher and Stover, *The Guantanamo Effect* (2009); Major General George R. Fay, "AR 15-6 Investigation of the Abu Ghraib Detention Facility and 205th Military Intelligence Brigade" (2004), 47, <http://f1.findlaw.com/news.findlaw.com/hdocs/docs/DoD/fay82504rpt.pdf>. The Fay report notes that medical doctors at Abu Ghraib claimed that "excellent" medical records were kept, but he could find no evidence of them.
- 157 Senate Armed Services Report (2008) [see note 41].
- 158 Lieutenant General Ricardo S. Sanchez, U.S. Department of the Army, Headquarters, Combined Joint Task Force Seven, "Memorandum for Commander, U.S. Central Command: CJTF-7 Interrogation and Counter-Resistance Policy" (September 14, 2003), <http://www.aclu.org/files/FilesPDFs/september%20sanchez%20memo.pdf>.
- 159 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008) [see note 28].
- 160 Lieutenant General Ricardo S. Sanchez, U.S. Department of the Army, Headquarters, Combined Joint Task Force Seven, "Memorandum for Commander, U.S. Central Command: CJTF-7 Interrogation and Counter-Resistance Policy" (14 September 2003), <http://www.aclu.org/files/FilesPDFs/september%20sanchez%20memo.pdf>.
- 161 *Ibid.*
- 162 Surgeon General Report (2005).
- 163 Church Report (2006).
- 164 U.S. Department of Defense, Sworn Statement by Thomas Pappas, AR 15-6 Investigation of the 800th Military Police Brigade (8 February 2004), <http://dSPACE.WRLC.org/doc/bitstream/2041/64697/01359display.pdf>; Lieutenant General Ricardo S. Sanchez, U.S. Department of the Army, "Memorandum for Commander, U.S. Central Command: CJTF-7 Interrogation and Counter-Resistance Policy" (14 September 2003); Steven Miles, *Oath Betrayed* (2006), 59.
- 165 Surgeon General Report (2005), 1-4.
- 166 Surgeon General Report (2005), chap. 18.
- 167 Church Report (2006), 358.
- 168 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008).
- 169 A handful of members of behavioral science consultation teams were interviewed separately.
- 170 Surgeon General Report (2005), 18-18, 18-21. Admiral Church's report found that the seven medical personnel, including one physician, had not participated in interrogation except to conduct pre- and post-interrogation medical exams.
- 171 *Ibid.*, 18-22, n. 4.
- 172 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008), 86.
- 173 Justine Sharrock, *Tortured: When Good Soldiers Do Bad Things* (Hoboken, NJ: John Wiley & Sons, Inc., 2010).
- 174 *Ibid.*, 116.
- 175 Karen Greenberg, *The Least Worst Place: Guantanamo's First 100 Days* (New York: Oxford University Press USA, 2009).

- 176 Fletcher and Stover, *The Guantanamo Effect* (2009) [see note 1]; Physicians for Human Rights, *Broken Laws, Broken Lives* (2008).
- 177 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005 and 2007).
- 178 Admiral Patrick Walsh, U.S. Department of Defense, *Review of Department Compliance with President's Executive Order on Detainee Conditions of Confinement* (2009), 52.
- 179 Leonard S. Rubenstein and George J. Annas, "Medical ethics at Guantanamo Bay detention center and in the US military: a time for reform," *The Lancet* 374 (2009): 353-355.
- 180 U.S. Department of Defense, "SECRET ORCON Interrogation Log: Detainee 063," *Time* (3 March 2006), <http://www.time.com/time/2006/log/log.pdf>.
- 181 Adam Zagorin and Michael Duffy, "Inside the Interrogation of Detainee 063," *Time* (20 June 2005), <http://www.time.com/time/magazine/article/0,9171,1071284,00.html>.
- 182 U.S. Department of Defense, Office of Inspector General, "Investigation of Allegations of the Use of Mind-Altering Drugs to Facilitate Interrogation of Detainees" (September 2009), http://www.thetorturedatabase.org/files/foia_subsite/dod_ig_report_mind-altering_drugs.pdf. See also Jeffrey Kaye and Jason Leopold, "DoD Report Reveals Some Detainees Interrogated While Drugged, Others 'Chemically Restrained,'" *Truthout* (11 July 2012), <http://truthout.org/news/item/10248-exclusive-department-of-defense-declassifies-report-on-alleged-drugging-of-detainees>.
- 183 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008).
- 184 U.S. Department of Defense, Office of Inspector General, "Investigation of Allegations of the Use of Mind-Altering Drugs to Facilitate Interrogation of Detainees" (September 2009).
- 185 *Washington v. Harper*, 494 U.S. 210 (1990).
- 186 U.S. Department of Defense, Office of Inspector General, "Investigation of Allegations of the Use of Mind-Altering Drugs to Facilitate Interrogation of Detainees" (September 2009).
- 187 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006), paragraph 4.7.2.
- 188 Human Rights Watch, *Locked Up Alone: Detention Conditions and Mental Health at Guantanamo* (New York: Human Rights Watch, 2008); Physicians for Human Rights and Human Rights First, *Leave No Marks: Enhanced Interrogation and the Risk of Criminality* (Physicians for Human Rights and Human Rights First, 2007).
- 189 Letter from T.J. Harrington, Deputy Assistant Director, Counterterrorism Division, Federal Bureau of Investigation, to Major General Donald J. Ryder, Department of the Army, Criminal Investigation Command (14 July 2004), http://www.aclu.org/torturefoia/released/FBI_4622_4624.pdf.
- 190 Human Rights Watch, *Locked Up Alone* (2008), 24-25, 36-37, 40.
- 191 Paisley Dodds, "Mass Suicide Attempts at Gitmo," *Associated Press* (11 February 2009), <http://www.cbsnews.com/stories/2004/11/30/terror/main658327.shtml>.
- 192 Neil Lewis, "Red Cross Finds Detainee Abuse in Guantanamo," *New York Times* (30 November 2004).
- 193 Scott Horton, "The Guantanamo 'Suicides': A Camp Delta sergeant blows the whistle," *Harper's Magazine* (March 2010), <http://harpers.org/archive/2010/03/the-guantanamo-suicides/>.
- 194 Charlie Savage, "Military Identifies Guantanamo Detainee Who Died," *New York Times* (11 September 2012), <http://www.nytimes.com/2012/09/12/us/politics/detainee-who-died-at-guantanamo-had-release-blocked-by-court.html>. See also "Death at Guantanamo Bay," Editorial, *New York Times* (16 September 2012), <http://www.nytimes.com/2012/09/16/opinion/sunday/death-at-guantanamo-bay.html>.
- 195 Fletcher and Stover, *The Guantanamo Effect* (2009) [see note 1].
- 196 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008).
- 197 Human Rights Watch, *Locked Up Alone* (2008).
- 198 Center for Constitutional Rights, *Current Conditions of Confinement at Guantanamo: Still in Violation of the Law* (New York: Center for Constitutional Rights, 23 February 2009), http://ccrjustice.org/files/CCR_Report_Conditions_At_Guantanamo.pdf.
- 199 Human Rights Watch, *Locked Up Alone* (2008).
- 200 Admiral Patrick Walsh, U.S. Department of Defense, *Review of Department Compliance with President's Executive Order on Detainee Conditions of Confinement* (2009), 52.
- 201 Leonard S. Rubenstein and George J. Annas, "Medical ethics at Guantanamo Bay detention center and in the US military: a time for reform," *The Lancet* 374 (2009): 353-355.
- 202 Vincent Iacopino and Stephen N. Xenaki, "Neglect of Medical Evidence of Torture in Guantanamo Bay: a case series," *PLoS Medicine* 8, no. 4 (2011), <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001027>.
- 203 See also Physicians for Human Rights, *Broken Laws, Broken Lives* (2008).
- 204 Carlotta Gall, "Threats and Responses: Captives; Tales of Despair from Guantanamo," *New York Times* (17 June 2003), <http://www.nytimes.com/2003/06/17/world/threats-and-responses-captives-tales-of-despair-from-guantanamo.html?pagewanted=all&src=pm>.
- 205 Affidavit of Emily Keram, *Al-Oshan v. Obama*, CA 05—520 (RMU) (D.D.C. 2 November 2009).
- 206 Paisley Dodds, "Mass Suicide Attempts at Gitmo," *Associated Press* (11 February 2009), <http://www.cbsnews.com/stories/2004/11/30/terror/main658327.shtml>.
- 207 Moazzam Begg, *Enemy Combatant: My Imprisonment at Guantanamo, Bagram, and Kandahar* (2006; repr., London: Simon & Schuster UK Ltd, 2007), 245.
- 208 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008).
- 209 Declaration of Bruce E. Vargo, *Zuhair v. Obama*, Civ. No. 08-CV-0864 (EGS) (D.D.C. 16 March 2009), http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/testimonies-of-the-defense-department/zuhair%20_v_obama_vargo_decl_20090316.pdf. Colonel Vargo was commander of all detention operations at Guantanamo Bay.
- 210 Human Rights Watch, *Locked Up Alone* (2008), 30 [see note 188].
- 211 *Ibid.*, 35.
- 212 Neil Lewis, "Red Cross Finds Detainee Abuse in Guantanamo," *New York Times* (30 November 2004).
- 213 The 2005 and 2007 medical guidelines do not specifically address the use of sedatives for non-therapeutic reasons, but imply their availability. U.S. Department of the Army,

- Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005 and 2007).
- 214 U.S. Department of Defense, Office of Inspector General, "Investigation of Allegations of the Use of Mind-Altering Drugs to Facilitate Interrogation of Detainees" (September 2009). See also Jeffrey Kaye and Jason Leopold, "DoD Report Reveals Some Detainees Interrogated While Drugged, Others 'Chemically Restrained,'" *Truthout* (11 July 2012), <http://truth-out.org/news/item/10248-exclusive-department-of-defense-declassifies-report-on-alleged-drugging-of-detainees>.
- The 2005 and 2007 medical guidelines state that health care personnel should only use restraints for medical purposes. U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005), 3-7. In light of the inspector general finding, however, this rule does not appear to apply to chemical restraints.
- 215 American Medical Association, Code of Medical Ethics, E-2.065, "Court-Initiated Medical Treatments in Criminal Cases," (1998), <http://www.ama-assn.org/resources/doc/PolicyFinder/policyfiles/HnE/E-2.065.HTM>.
- 216 National Commission for Correctional Health Care, Standards for Health Services in Prisons 2003, P-1-02, "Emergency Psychotropic Medication."
- 217 Remington Nevin, "Mass administration of the antimalarial drug mefloquine to Guantanamo detainees: a critical analysis," *Tropical Med & International Health* (12 August 2012), <http://www.ncbi.nlm.nih.gov/pubmed/22882560>; Leopold and Kaye, "Controversial Drug Given to All Detainees Akin to 'Pharmacological Waterboarding,'" *Truthout* (1 December 2010), <http://www.truth-out.org/news/item/253-exclusive-controversial-drug-given-to-all-guantanamo-detainees-akin-to-pharmacologic-waterboarding>; Mark Denboux and others, *Drug Abuse: An exploration of the government's use of mefloquine at Guantanamo* (Newark, NJ: Seton Hall University School of Law Center for Policy and Research, 2010), <http://law.shu.edu/ProgramsCenters/PublicIntGovServ/policyresearch/upload/drug-abuse-exploration-government-use-mefloquine-guantanamo.pdf>.
- 218 The Task Force has no information about whether any reports of abuse were submitted by medical personnel at the CIA, whether any such reports were investigated, and if they were investigated, whether any disciplinary action was taken.
- 219 Central Intelligence Agency, Office of the Inspector General, *Special Review: Counterterrorism Detention and Interrogation Activities (September 2001-October 2003)* (7 May 2004), http://media.luxmedia.com/aclu/JG_Report.pdf.
- 220 Justine Sharrock, *Tortured: When Good Soldiers Do Bad Things* (2010) [see note 173]; Joshua E. S. Phillips, "Inside the Detainee Abuse Task Force," *The Nation* (13 May 2011), <http://www.thenation.com/article/160560/inside-detainee-abuse-task-force>.
- 221 U.S. Department of Defense, Directive 5100.77, "DoD Law of War Program" (1998), <http://biotech.law.lsu.edu/blaw/DoDd/corres/pdf2/d510077p.pdf>; U.S. Department of Defense, Directive 3115.09, "DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning" (November 2005), <http://www1.umn.edu/humanrts/OathBetrayed/Interrogation%20Directive%203115.09.pdf>. This directive was revised in 2008 (http://www.fas.org/irp/DoDdir/DoD/d3115_09.pdf).
- 222 Surgeon General Report (2005), chap. 17 [see note 29].
- 223 Surgeon General Report (2005), chaps. 14-16.
- 224 Church Report (2006), 354-55 [see note 138].
- 225 Surgeon General Report (2005), 14-1, 14-2.
- 226 Surgeon General Report (2005), chap. 20. There exist documented instances where physicians did not inquire into the injuries a detainee received or did not seek to learn the source of the injury. There are a few exceptional cases where a physician did report abuse appropriately; see Steven Miles, *Oath Betrayed* (2006), 122-124 [see note 27].
- 227 Surgeon General Report (2005).
- 228 Church Report (2006), 359.
- 229 Major General George R. Fay, "AR 15-6 Investigation of the Abu Ghraib Detention Facility and 205th Military Intelligence Brigade" (2004), 80, <http://fl1.findlaw.com/news.findlaw.com/hdocs/docs/DoD/fay82504rpt.pdf>.
- 230 *Ibid.*, 355-56.
- 231 *Ibid.*
- 232 Steven Miles, *Oath Betrayed* (2006), 73-74.
- 233 Scott Allen and others, "Deaths of Detainees in Custody of US Forces in Iraq and Afghanistan from 2002-2005," *MedGenMed* 8, no. 4 (2006): 46.
- 234 Steven Miles and Andrea Smith, "United States Defense Department Reporting of War-on-Terror Prisoner Deaths," (unpublished paper, no date).
- 235 U.S. Department of Justice, Office of Legal Counsel, "Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, Re: Application of 18 U.S.C. §§2340-2340A to the Combined Use of Certain Techniques in the Interrogation of High Value al Qaeda Detainees" (May 2005), <http://www.fas.org/irp/agency/doj/olc/combined.pdf>.
- 236 ICRC Report (2007), 7 [see note 64].
- 237 *Ibid.*, 10.
- 238 *Ibid.*, 13.
- 239 *Zubaydah v. Lithuania*, Eur. Ct. H.R. (27 October 2011), para. 153, <http://www.interights.org/document/181/index.html>.
- 240 ICRC Report (2007), 13.
- 241 Some of these accounts are collected in Human Rights Watch, *Locked Up Alone* (2008) [see note 188].
- 242 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008) [see note 28].
- 243 *Ibid.*, 89.
- 244 Fletcher and Stover, *The Guantanamo Effect* (2009) [see note 1].
- 245 Human Rights Watch, *Locked Up Alone* (2008).
- 246 Fletcher and Stover, *The Guantanamo Effect* (2009).
- 247 Physicians for Human Rights, *Broken Laws, Broken Lives* (2008).

CHAPTER 2

- 1 Robert Jay Lifton, "Doctors and Torture," *New England Journal of Medicine* 351 (2004): 415-416; Brewer and Arrigo, "Places that Medical Ethics Can't Find" and Jonathan Marks, "Looking Back, Thinking Ahead: The Complicity of Health Professionals in Detainee Abuse," in *Interrogation, Forced Feedings and the Role of Health Professionals*, ed. Goodman and Roseman (2009); Kelman and Hamilton, *Crimes of Obedience* (1990); Philip Zimbardo, *The Lucifer Effect* (2007); Stanley Milgram, "Behavioral Study of Obedience," *Journal of Abnormal and Social Psychology* 67, no. 4 (1963): 371-378; Thomas Beam, "Medical Ethics on the Battlefield: The Crucible of Military Medical Ethics" in U.S. Department of the Army, Office of the Surgeon General, *Military Medical Ethics*, Vol. 2 (2003).
- 2 UN General Assembly, Resolution 37/194, "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" (18 December 1982), <http://www.un.org/documents/ga/res/37/a37r194.htm>.
- 3 Sessums and others, "Ethical Practice Under Fire: Deployed Physicians in the Global War on Terrorism," *Military Medicine* 174, no. 5. (2009): 441-447; Lieutenant General Ronald Blanck, U.S. Army Surgeon General (ret), personal communication cited in Thomas E. Beam and Edmund G. Howe, "A Proposed Ethic for Military Medicine" in U.S. Department of the Army, Office of the Surgeon General, *Military Medical Ethics*, vol. 2 (2003). See also World Medical Association, *WMA Regulations in Times of Armed Conflict and Other Situations of Violence* (1956; revised Bangkok: WMA General Assembly, October 2012), <http://www.wma.net/en/30publications/10policies/a20/index.html>; 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* (March 2003), <http://physiciansforhumanrights.org/library/reports/dual-loyalty-and-human-rights-2003.html>; National Commission on Correctional Health Care, Position Statement, "Correctional Health Care Professionals' Response to Inmate Abuse" (2007), <http://www.ncchc.org/correctional-health-care-professionals%E2%80%99-response-to-inmate-abuse>.
- 4 UN General Assembly, Resolution 37/194, "Principles of Medical Ethics" (1982), Principle 5.
- 5 Ibid., Principle 2.
- 6 World Medical Association, *Declaration of Tokyo* (1975; revised May 2006), www.wma.net/en/30publications/10policies/c18/index.html.
- 7 "Against Torture: Joint Resolution of the American Psychiatric Association and the American Psychological Association" (Washington, DC: American Psychological Association, 1985), <http://www.apa.org/news/press/statements/joint-resolution-against-torture.pdf>.
- 8 "American College of Physicians Ethics Manual, Third Edition," *Annals of Internal Medicine* 117, no. 11 (1 December 1992): 947-960, <http://www.ncbi.nlm.nih.gov/pubmed/1443957>; American College of Physicians, "The Role of the Physician and the Medical Profession in the Prevention of International Torture and in the Treatment of Its Survivors," *Annals of Internal Medicine* 122, no. 8 (1995): 607-613.
- 9 American Medical Association, Code of Medical Ethics, Opinion 2.067, "Torture" (1999).
- 10 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006), <http://www.dtic.mil/whs/directives/corres/pdf/231008p.pdf>.
- 11 Ibid.
- 12 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2007), 1-9 and following.
- 13 Central Intelligence Agency, Office of Medical Services, "OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation and Detention" (May 2004), <http://www.aclu.org/torturefoia/released/103009/cia-olc/2.pdf>.
- 14 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006).
- 15 M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *New England Journal of Medicine* 352, no. 1 (2005): 3-6.
- 16 Leonard Rubenstein and others, "Coercive US Interrogation: A Challenge to Medical Ethics," *JAMA* 294, no.12 (2005): 1544-1549.
- 17 A side-by-side comparison of the language is contained in Table A of Leonard Rubenstein and others, "Coercive US Interrogation: A Challenge to Medical Ethics," *JAMA* 294, no.12 (2005): 1544-1549.
- 18 Jordan J. Cohen, Sylvia Cruess, and Christopher Davidson, "Alliance Between Society and Medicine: The Public's Stake in Medical Professionalism," *JAMA* 298, no. 6 (2007): 760-77; M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *New England Journal of Medicine* 352, no. 1 (2005): 3-6; George J. Annas, "Military Medical Ethics - Physician First, Last, Always," *New England Journal of Medicine* 359 (2008):1087-1090.
- 19 World Medical Association, *Declaration of Tokyo* (1975; revised May 2006).
- 20 "American College of Physicians Ethics Manual, Fifth Edition," *Annals of Internal Medicine* 142, no. 7 (2005): 560-582, <http://annals.org/article.aspx?articleid=718312>.
- 21 American Psychiatric Association, Position Statement, "Psychiatric Participation in Interrogation of Detainees" (2006), http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2006_Interrogation.pdf.
- 22 Paul S. Appelbaum, "Coping With the Ethical Conundra of Forensic Psychiatry: A Tribute to Howard Zonana, MD," *Journal of the American Academy of Psychiatry and the Law* 38 (2010): 551-558.
- 23 Ibid.
- 24 American Medical Association, Code of Medical Ethics, Opinion 2.068, "Physician Participation in Interrogation," (2006), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2068.page>.
- 25 Frederick E. Turton and Lois Snyder, "Revision to the American College of Physicians' Ethics Manual," *Annals of Internal Medicine* 148, no. 11 (2008): 887-888, http://www.acponline.org/running_practice/ethics/manual/physician_participation.pdf.
- 26 American Medical Association, Code of Medical Ethics, Opinion 1.02, "The Relation of Law and Ethics," (issued prior to April 1977), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion102.page>.
- 27 American Psychological Association, *Report of American Psychological Association Presidential Task Force on Psychological Ethics and National Security* (Washington, DC: American

- Psychological Association, June 2005), <http://www.apa.org/pubs/info/reports/pens.pdf> [henceforth cited as PENS Report (2005)].
- 28 Stephen Soldz, "Closing Eyes to Atrocities: U.S. Psychologists, Detainee Interrogations, and the Response of the American Psychological Association" in *Interrogation, Forced Feedings and the Role of Health Professionals*, ed. Ryan Goodman and Mindy Roseman (Cambridge, MA: Human Rights Program, Harvard Law School, 2009); Kenneth S. Pope, "Psychologists and Detainee Interrogations: Key Decisions, Opportunities Lost, and Lessons Learned," *Annual Review of Clinical Psychology* 7 (2011): 16.1-16.23.
- 29 Leonard S. Rubenstein, "Complicity and the Illusion of Beneficence" in *Interrogation, Forced Feedings and the Role of Health Professionals*, ed. Goodman and Roseman (2009).
- 30 American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, Standard 3.04, "Avoiding Harm" (2002), <http://www.apa.org/ethics/code/index.aspx?item=6>.
- 31 This was based on APA Ethical Standard 1.02. PENS Report (2005), 5. In 2010, the standard allowing deference to law was changed to state that under no circumstances was deference to law a grounds for violating human rights. See <http://www.apa.org/news/press/releases/2010/02/ethics-code.aspx>.
- 32 PENS Report (2005), 2.
- 33 Stephen Soldz, "Closing Eyes to Atrocities: U.S. Psychologists, Detainee Interrogations, and the Response of the American Psychological Association" in *Interrogation, Forced Feedings and the Role of Health Professionals*, ed. Ryan Goodman and Mindy Roseman (Cambridge, MA: Human Rights Program, Harvard Law School, 2009); Kenneth S. Pope, "Psychologists and Detainee Interrogations: Key Decisions, Opportunities Lost, and Lessons Learned," *Annual Review of Clinical Psychology* 7 (2011): 16.1-16.23.
- 34 American Psychological Association, "Amendment to the Reaffirmation of the American Psychological Association Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined in the United States Code as 'Enemy Combatants'" (2 February 2008), <http://www.apa.org/ethics/programs/statement/torture-code.aspx>. The membership of the American Psychological Association also passed a referendum prohibiting psychologists to work in any detention facility where violations of the Convention Against Torture, the Geneva Conventions, or the U.S. Constitution are taking place (American Psychological Association Council of Representatives Meeting, Feb 20-22, 2009, <http://www.AmericanPsychologicalAssociation.org/about/governance/council/09feb-cminutes.aspx>).
- 35 American Psychological Association, "2008 APA Petition Resolution Ballot," <http://www.apa.org/news/press/statements/work-settings.aspx>.
- 36 Richard Knox, "Psychiatrists Protest Pentagon Interrogations," *National Public Radio* (26 September 2008), <http://wap.npr.org/story/95068929>.
- 37 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005), 1-11, <http://www.globalsecurity.org/military/library/policy/army/other/st4-02-46.pdf>.
- 38 American Academy of Psychiatry and the Law, "Ethics Guidelines for the Practice of Forensic Psychiatry" (Bloomberg, CT: American Academy of Psychiatry and the Law, May 2005), <http://www.aapl.org/ethics.htm>.
- 39 U.S. Department of the Army, Headquarters, U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 11; U.S. Department of the Army, Headquarters, U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009), 11, http://www.ethicalpsychology.org/materials/U.S._Army_Behavioral_Science_Consultation_Team_Policy_2008.pdf.
- 40 American Psychological Association, *Specialty Guidelines for Forensic Psychology* (Washington, DC: American Psychological Association, 3 August 2011), http://www.ap-ls.org/aboutpsychlaw/SGFP_Final_Approved_2011.pdf.
- 41 *Ibid.*, sec. 6.03.
- 42 In its 2012 BSCT guidance, the U.S. Army states that where BSCTs conduct evaluations of detainees through interviews or psychometric tests, they must disclose that the assessments are not for medical purposes. OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 9, 14. In a major deviation from the requirements of the American Psychological Association's forensic standards, however, the purpose, nature, and anticipated use of the results of the examination are not disclosed.
- 43 American Psychological Association, *Specialty Guidelines for Forensic Psychology* (2011), sec. 1.03.
- 44 *Ibid.*, sec. 6.03.04.
- 45 PENS Report (2005) [see note 27].
- 46 American Psychological Association, *Specialty Guidelines for Forensic Psychology* (2011), sec. 1.03.
- 47 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006).
- 48 OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009), 18; OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 19.
- 49 OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 19; OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009), 18.
- 50 OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009), 26.
- 51 OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 28.
- 52 American Medical Association, Code of Medical Ethics, Opinion 2.068, "Physician Participation in Interrogation," (2006). The surgeon general's claim about the American Medical Association's position is based on a background paper to the policy, which is not part of

- the ethical code that was subject to a vote, and indeed the association states that the report is not to be cited or referenced without permission.
- 53 American Medical Association, Report of the Council on Ethical and Judicial Affairs, "CEJA Report 10-A-06: Physician Participation in Interrogation" (Chicago: American Medical Association, 2006), <http://www.ama-assn.org/resources/doc/code-medical-ethics/2068a.pdf>.
- 54 PENS Report (2005) [see note 27]. Page 2 states:
As a context for its statements, the PENS Task Force affirmed that when psychologists serve in any position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies that "The Task Force thus rejects the contention that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethical Principles of Psychologists.
- 55 OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009), 18; OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 20.
- 56 OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009), 20; OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 21.
- 57 Compare the following two sources: UN General Assembly, Resolution 37/194, "Principles of Medical Ethics" (1982); U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006).
- 58 OMS Guidelines (May 2004), 10 [see note 13]. The Task Force finds a redaction in a statement of an ethical responsibility, watered down as it may be, additionally troubling.
- 59 "Definitions," *U.S. Code* 18 (1994), § 2340A.
- 60 OMS Guidelines (May 2004), 9, n2.
- 61 Leonard S. Rubenstein, "Physicians and Psychologists as Enablers of Torture" in *Terrorism and Public Health: A Balanced Approach to Strengthening Systems and Protecting People*, ed. Barry S. Levy and Victor W. Sidel (New York: Oxford University Press USA, 2011); Leonard S. Rubenstein, "Complicity and the Illusion of Beneficence" in *Interrogation, Forced Feedings and the Role of Health Professionals*, ed. Goodman and Roseman (2009) [see note 28].
- 62 Leonard S. Rubenstein, "Physicians and Psychologists as Enablers of Torture" in *Terrorism and Public Health* (2011); Physicians for Human Rights, *Experiments in Torture: Evidence of Human Subject Research and Experiments in the "Enhance" Interrogation Program* (Cambridge, MA: Physicians for Human Rights, 2010), <http://phrtorturepapers.org/>; Leonard Rubenstein and Stephen Xenakis, "Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees," *JAMA* 304, no. 5 (2010): 569-570.
- 63 OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012); Larry C. James, *Fixing Hell: An Army Psychologist Confronts Abu Ghraib* (Grand Central Publishing, 2008).
- 64 OMS Guidelines (May 2004).
- 65 British Medical Association, *The Medical Profession and Human Rights: Handbook for a Changing Agenda* (London: Zed Books, 2001), 72-76.
- 66 PENS Report (2005), 2 [see note 27].
- 67 Larry C. James, *Fixing Hell* (2008).
- 68 World Medical Association, *Declaration of Tokyo* (1975; revised May 2006).
- 69 Ibid.
- 70 American Medical Association, Code of Medical Ethics, Opinion 5.05, "Confidentiality" (1983).
- 71 American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, Standard 4.02(a), "Discussing the Limits of Confidentiality" (2002). The American Psychological Association's Presidential Task Force on Psychological Ethics and National Security, which approved a role for psychologists in national security interrogation, mentions standard 4.02 but fails to address the requirement of disclosure of potential uses of the information to the detainee.
- 72 Peter Slevin and Joe Stephens, "Detainees' medical files shared," *Washington Post* (10 June 2004); Neil Lewis, "Red Cross Finds Detainee Abuse at Guantanamo," *New York Times* (30 November 2004), <http://www.nytimes.com/2004/11/30/politics/30gitmo.html>, citing International Committee of the Red Cross, *ICRC Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody* (2007); Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006), 54-55.
- 73 U.S. Department of Defense, United States Southern Command, "Policy Memorandum 8-02: U.S. Southern Command Confidentiality Policy Between Health Care Providers and Enemy Persons Under U.S. Control, Detained in Conjunction with Operation ENDURING FREEDOM" (6 August 2002), <http://dspace.wrlc.org/doc/bitstream/2041/63600/00361display.pdf>.
- 74 U.S. Department of Defense, JTF GTMO, "BSCT Standard Operation Procedures" (11 November 2002), <http://www.americantorture.com/documents/gitmo/05.pdf>.
- 75 Larry C. James, *Fixing Hell* (2008), 56-57. James states that he reformed the process to prevent interrogators from gaining access to medical records, but concedes that behavioral science consultants had access to detainee medical information and could discuss the information with the medical staff. He further claimed that the purpose of behavioral science consultant access to medical records was solely to ensure "that no detainee would ever be harmed." Ibid., 58. This claim, however, is inconsistent with DoD policies on the role of the behavioral science consultants, who are expected to identify detainee vulnerabilities.
- 76 U.S. Department of the Army, Office of the Surgeon General, *Final Report: Assessment of Detainee Medical Operations for OEF, GTMO, and OIF* (2005), sec. 18-13, http://www.globalsecurity.org/military/library/report/2005/detmedopsrpt_13apr2005.pdf [hereafter cited as Surgeon General Report (2005)].
- 77 Surgeon General Report (2005), 7-5.
- 78 U.S. Department of Defense, Office of the Secretary of Defense, *Review of Defense Detention Operations and Detainee Interrogation Techniques*, by Admiral A.T. Church (2006), 359, http://www.aclu.org/images/torture/asset_upload_file625_26068.pdf (redacted version) and http://www.aclu.org/files/pdfs/safefree/church_353365_20080430.pdf (pages that were originally redacted).

- 79 Behavioral Science Consultation Team, Joint Intelligence Group, Joint Task Force - Guantanamo, Standard Operating Procedures (2005), <http://www.aclu.org/files/projects/foiasearch/pdf/DODDON000760.pdf>.
- 80 Ibid., Annex C.
- 81 Ibid.
- 82 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005), 1-11, 1-12; Surgeon General Report (2005), 1-9; Matthew K. Wynia, "Breaching confidentiality to protect the public: evolving standards of medical confidentiality for military detainees," *American Journal of Bioethics* 7, no. 8 (2007):1-5.
- 83 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005), 1-11, 1-12. The first reference to keeping interrogation "safe, legal, ethical, and effective" the Task Force is aware of was from a memorandum on BSCT responsibilities in December 2004. U.S. Department of Defense, JTF GTMO, "Operational Policy Memorandum #14, Behavioral Science Consultation Team" (10 December 2004), http://upload.wikimedia.org/wikipedia/commons/1/14/BSCT_Standard_Operating_Procedures_-_2002-11-11.pdf (starting at page 3). The phrase is repeated in subsequent BSCT standard operating procedures.
- 84 Ibid., 1-11.
- 85 The policies are reflected in the detailed medical guidance regarding health care for detainees. It states that only health care personnel charged with assistance in the interrogation process, including "interpretation of medical records and information," are not to be involved in health care services. In other words, the BSCTs are permitted to review medical records and share information from them with interrogators. U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2007), 1-12.
- 86 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006).
- 87 Ibid.
- 88 *Health Insurance Portability and Accountability Act of 1996*, Public Law 191, 104th Cong. (21 August 1996), § 512(K)(2).
- 89 Admiral Patrick Walsh, U.S. Department of Defense, *Review of Department Compliance with President's Executive Order on Detainee Conditions of Confinement* (2009), http://www.defense.gov/pubs/pdfs/review_of_department_compliance_with_presidents_executive_order_on_detainee_conditions_of_confinementa.pdf.
- 90 OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009).
- 91 Ibid., 28.
- 92 OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 10.
- 93 Ibid., 8.
- 94 Ibid., 9.
- 95 Ibid.
- 96 Ibid., 10.
- 97 U.S. Department of Defense, Directive 3115.09, "DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning," (2008; revised October 2012), Enclosure 3, <http://www.dtic.mil/whs/directives/corres/pdf/311509p.pdf>.
- 98 OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 23.
- 99 Ibid., 8.
- 100 The requirement for reporting violations of the law of war in effect after 9/11 derived from the DoD Law of War Program. U.S. Department of Defense, Directive 5100.77, "DoD Law of War Program" (1998), <http://biotech.law.lsu.edu/blaw/DoDd/corres/pdf/d510077p.pdf>.
- 101 Surgeon General Report (2005), 16-2 [see note 77], citing U.S. Department of Defense, Directive 5100.77, "DoD Law of War Program" (1998). Directive 5100.77 was superseded by Directive 2311.01E (<http://www.dtic.mil/whs/directives/corres/pdf/231101e.pdf>).
- 102 Office of the United Nations High Commissioner For Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)* (New York and Geneva: United Nations, 2004), <http://www.unhcr.org/refworld/docid/4638aca62.html>; Vincent Iacopino, Onder Ozkalipci, and Caroline Schlar, "The Istanbul Protocol: international standards for the effective investigation and documentation of torture and cruel, inhuman, or degrading treatment," *The Lancet* 354, no. 1117 (1993).
- 103 U.S. Department of Defense, Army Regulation 15-6: Final Report, Investigation into FBI Allegations of Detainee Abuse at Guantanamo Bay, Cuba Detention Facility (April 2005), <http://www.defense.gov/news/Jul2005/d20050714report.pdf>.
- 104 Surgeon General Report (2005), 16-2.
- 105 Ibid.
- 106 Surgeon General Report (2005), 16-15. The manual was written in 2001 and is available at https://s3.amazonaws.com/PHR_Reports/examining-asylum-seekers-manual.pdf.
- 107 U.S. Department of Defense, United States Southern Command, "USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at US Naval Base Guantanamo Bay, Cuba" (9 August 2004), para. 10a, <http://dspace.wrlic.org/doc/bitstream/2041/66357/02539display.pdf>.
- 108 U.S. Department of Defense, Detention Hospital, Guantanamo Bay, Cuba, "SOP No: 007 Medical Documentation and Reporting Procedure for Suspected Detainee Abuse" (February 2005, revised June 2005), <http://dspace.wrlic.org/doc/bitstream/2041/66769/02951display.pdf>. The Task Force is not aware whether this SOP is still in place or has been revised or rescinded.
- 109 U.S. Department of Defense, Assistant Secretary of Defense for Health Affairs, HA Policy 05-006, "Medical Program Principles and Procedures for the Protection and Treatment of

- Detainees in the Custody of the Armed Forces of the United States” (3 June 2005), Procedures, para. 4.
- 110 U.S. Department of Defense, Instruction 2310.08E, “Medical Program Support for Detainee Operations” (6 June 2006).
- 111 U.S. Department of Defense, Assistant Secretary of Defense for Health Affairs, HA Policy 05-19 (13 October 2005).
- 112 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2005). See also updated version, U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2007), 1-14.
- 113 *Ibid.*, 1-13.
- 114 *Ibid.*
- 115 *Ibid.*, 1-14. The examiner must be a licensed health care provider.
- 116 Alberto Moreno and Vincent Iacopino, “Forensic Investigations of Torture and Cruel, Inhuman or Degrading Treatment in Mexico: A Follow-Up Study After the Implementation of the Istanbul Protocol,” *Journal of Legal Medicine* 29, no. 4 (2008): 443-478; Vincent Iacopino and others, “Physician Complicity in Misrepresentation and Omission of Medical Evidence in Post-Detention Medical Examinations in Turkey,” *JAMA* 276 (1996): 396-402.
- 117 U.S. Department of the Army, Headquarters, United States Army Medical Department Center, Medical Support To Detainee Operations, Special Text No. 4-02.46 (2007), 1-14.
- 118 U.S. Department of Defense, Directive 3115.09, “DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning” (2008; revised October 2012).
- 119 *Ibid.*
- 120 *Ibid.*, Enclosure 3.
- 121 OTSG/MEDCOM Policy Memo 13-027, “US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning,” (2012).
- 122 U.S. Department of Defense, DoD 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation* (2004), C10.9.1.3, <http://www.dtic.mil/whs/directives/corres/pdf/602513r.pdf>.
- 123 “Licensure Requirement for Health-Care Professionals,” *U. S. Code* 10 (2011) § 1094; U.S. Department of Defense, Instruction 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)” (17 February 2011), <http://www.dtic.mil/whs/directives/corres/pdf/602513p.pdf>.
- 124 Providers who are assigned to Geographically Separated Units, i.e., are physically separated from their host unit but are supported by and are under the command and control of the host unit commander, are still reviewed for adverse actions. If an adverse action is being considered on a privileged or non-privileged provider in the theater of operations, the deployed military treatment facility will consider the information found during inquiry and make the decision to return the provider to the originating treatment facility for action.
- 125 The National Practitioner Data Bank was established by Congress to improve the quality of health care by encouraging state licensing boards, hospitals, professional societies, and other health care organizations to identify and discipline those who engage in unprofessional behavior, to report medical malpractice payments, and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history. See <http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp>.
- 126 The purpose of CCQAS is to collect, track, and report required provider data for DoD component credentialing and granting of clinical privileges. U.S. Department of Defense, Instruction 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)” (17 February 2011), 201.
- 127 U.S. Department of Defense, Instruction 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)” (17 February 2011).
- 128 *Ibid.*
- 129 The surgeon generals must also report, at least annually, management information regarding adverse privileging actions to the DoD Risk Management Committee, which is the primary oversight body of the assistant secretary of defense for health affairs for monitoring reporting of malpractice and adverse privileging actions to the National Practitioner Databank. The Department of Legal Medicine also submits information to the Risk Management Committee regarding adverse privileging actions.
- 130 U.S. Department of Defense, DoD 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation* (2004), secs. C10.9.1.3, DL1.1.3., DL1.1.36, <http://www.dtic.mil/whs/directives/corres/pdf/602513r.pdf>.
- 131 U.S. Air Force, Instruction 44-119, “Medical Quality Operations” (2007), secs. 5.2, 5.3.4.
- 132 See, e.g., U.S. Department of the Navy, Health Care Quality Assurance Policies for Operating Forces, OpNav Instruction 6320.7A/Marine Corps Order 6320.4 (2007), sec. 9, <http://doni.daps.dla.mil/Directives/06000%20Medical%20and%20Dental%20Services/06-300%20General%20Medicine%20Support/6320.7A.pdf>.

CHAPTER 3

- 1 U.S. Department of Defense, Instruction 2310.08E, “Medical Program Support for Detainee Operations” (6 June 2006), <http://www.dtic.mil/whs/directives/corres/pdf/231008p.pdf>.
- 2 Hernán Reyes, “Medical and Ethical Aspects of Hunger Strikes in Custody and the Issue of Torture,” in *Maltreatment and Torture*, ed. Manfred Oehmichen (Lübeck: Schmidt-Römhild, 1998). See also Jean-Pierre Restellini, “Les grèves de la faim en pénitentiaire,” *Revue Pénale Suisse* 106 (1989).
- 3 See, e.g., George J. Annas, “Hunger Strikes at Guantanamo - Medical Ethics and Human Rights in a ‘Legal Black Hole,’” *New England Journal of Medicine* 355, no. 13 (28 Sept 2006); Michael Ratner, “How We Closed the Guantanamo HIV Camp: The Intersection of Politics and Litigation,” *Harvard Human Rights Journal* 11 (1998): 187-220; Stonecipher and Sneed, “Prisoner Fasting as Symbolic Speech: The Ultimate Speech-Action Test,” *Howard Law Journal* 32 (1989):

- 549-560; Wei and Brendel, "Psychiatry and Hunger Strikes" *Harvard Human Rights Journal* 23 (2010): 76-109.
- 4 Jeanne Smeulers, "Medical background of hunger strikers" in *Assistance in hunger strikes: a manual for physicians and other health personnel dealing with hunger strikers*, Johannes Wier Foundation for Health and Human Rights (Amersfoort: Johannes Wier Foundation, 1995).
- 5 David Beresford, *Ten Men Dead: The Story of the 1981 Irish Hunger Strike* (New York: Atlantic Monthly Press, 1987).
- 6 NY Oguz and SH Miles, "The physician and prison hunger strikes: reflecting on the experience in Turkey" *Journal of Medical Ethics* 31 (2005): 169-172.
- 7 World Medical Association, web-based course, "Doctors Working in Prison: Human Rights and Ethical Dilemmas" (2004), chap. 5, <http://www.wma.net/en/70education/10onlinecourses/20prison/index.html>.
- 8 At Guantanamo, protocols refer to this form of a hunger strike as voluntary fasting; a dry fast is called voluntary total fasting.
- 9 World Medical Association, "WMA Declaration of Malta - A Background Paper on the Ethical Management of Hunger Strikes," *World Medical Journal* 52, no. 2 (June 2006): 32.
- 10 The appearance of ketone bodies in the breath will depend on many factors, including body mass and fat, but generally speaking this rule of thumb has been found to work in the majority of cases.
- 11 However, there was one death at 43 days.
- 12 See World Medical Association, web-based course, "Doctors Working in Prison: Human Rights and Ethical Dilemmas" (2004), chap. 5.
- 13 World Medical Association, *Declaration of Tokyo* (1975), Article 5, www.wma.net/en/30publications/10policies/c18/index.html. In the 2006 revised version of the Declaration of Tokyo, it is numbered article 6, but the wording is the same.
- 14 Personal communication by the late Dr. André Wynen, former and honorary secretary-general and founding member of the World Medical Association, documented in the *travaux préparatoires*.
- 15 Letter from Karin Moran, American Medical Association, to William Hopkins and Sherman Carroll, Medical Foundation for Victims of Torture (15 March 2006); American Medical Association, "AMA Reiterates Opposition to Feeding Individuals Against Their Will," *American Medical News* (10 March 2006).
- 16 Written statement to a Task Force member by a Northern Ireland Senior Medical Officer who was involved at the time in the Irish hunger strikes.
- 17 Initially, the revisions were addressed to the questions arising in the hunger strikes in Turkey. As the process of revision moved forward, the new declaration also took into account the different but also troubling situation of responses to hunger strikes at Guantanamo Bay. The return to force-feeding was one of the main reasons for the World Medical Association's addressing the ethical principles that apply to hunger strikes. See Hernán Reyes, "Force-Feeding and Coercion: No Physician Complicity," virtual Mentor, *American Medical Association Journal of Ethics* 9, no. 10 (October 2007): 703-708.
- 18 World Medical Association, *WMA Declaration of Malta on Hunger Strikers* (1991, revised 2006), <http://www.wma.net/en/30publications/10policies/h31/index.html>.
- 19 *Ibid.*, Principle 3.
- 20 One of the four core principles of medical ethics. See World Medical Association, "WMA Declaration of Malta - A Background Paper on the Ethical Management of Hunger Strikes," *World Medical Journal* 52, no. 2 (June 2006).
- 21 British Medical Association, *Medical Ethics Today: The BMA's Handbook of Ethics and Law*, 2nd ed. (London: British Medical Association, 2004), 602-607, 623-625.
- 22 Malta Declaration (2006), Guidelines and Article 13.
- 23 *Ibid.*, Guideline 11.
- 24 Scott A. Allen and Hernán Reyes, "Clinical and Operational Issues in the Medical Management of Hunger Strikers" in *Interrogation, Forced Feedings and the Role of Health Professionals*, ed. Ryan Goodman and Mindy Roseman (Cambridge, MA: Human Rights Program, Harvard Law School, 2009); Johannes Wier Foundation for Health and Human Rights, *Assistance in hunger strikes: a manual for physicians and other health personnel dealing with hunger strikers* (Amersfoort: Johannes Wier Foundation, 1995).
- 25 Malta Declaration (2006), Principle 7.
- 26 Physicians are often seen by prisoners first and foremost as agents of the detaining authority, which is naturally perceived as acting against prisoners' interests if only by virtue of the situation of custody and confinement. In the context of indefinite detention in times of conflict, animosity and distrust will obviously be heightened.
- 27 Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006).
- 28 Malta Declaration (2006), Principle 5. Without these efforts, authorities will likely follow their own, often coercive, path. See George J. Annas, "American Vertigo: 'Dual Use,' Prison Physicians, Research, and Guantanamo" *Case Western Reserve Journal of International Law* 43 (2011): 631-650. National medical associations need to provide support for physicians confronted by such situations, and if necessary appeal to supra-national entities such as the World Medical Association for guidance.
- 29 Malta Declaration (2006), Principle 5 [see note 18].
- 30 *Ibid.*, Clinical Guideline 5.
- 31 See Bruno Gravier and others, "Une grève de la faim est un acte de protestation - Quelle est la place des soignants?" *Bulletin des Médecins Suisses* 39 (2010): 1521-25, which describes the role of the medical staff, particularly regarding the issue of determining informed consent.
- 32 Hernán Reyes, "Medical and Ethical Aspects of Hunger Strikes in Custody and the Issue of Torture," in *Maltreatment and Torture*, ed. Manfred Oehmichen (Lübeck: Schmidt-Römhild, 1998).
- 33 Malta Declaration (2006), Clinical Guidelines 1, 2, and 3.
- 34 Marlynn Wei and Rebecca W. Brendel, "Psychiatry and Hunger Strikes," *Harvard Human Rights Journal* 23 (2010): 76-109. Psychiatrists insist that a psychiatric evaluation is necessary in all cases. The Task Force believes that some mental disorders disqualify a prisoner from the

- “status” of hunger striker, and make that prisoner a full-fledged patient requiring medical attention. A prisoner refusing to eat because of a mental affliction, such as severe depression, may be reasonably declared incompetent to refuse treatment, and psychiatrists may even prescribe force-feeding, if and when such feeding is necessary to sustain his life. To the extent that individual competency assessment has been properly conducted, some form of force-feeding may thus, in such a case, be medically indicated.
- 35 See World Medical Association, “WMA Declaration of Malta - A Background Paper on the Ethical Management of Hunger Strikes,” *World Medical Journal* 52, no. 2 (June 2006): 32; Wei and Brendel, “Psychiatry and Hunger Strikes,” *Harvard Human Rights Journal* 23 (2010): 76-109.
- 36 World Medical Association, “WMA Declaration of Malta - A Background Paper on the Ethical Management of Hunger Strikes,” *World Medical Journal* 52, no. 2 (June 2006): 32, Case Example 1.
- 37 Malta Declaration (2006), Guideline 3. Some ailments or diseases are contra-indications to total fasting, including gastritis, peptic ulcers, and diabetes mellitus.
- 38 *Ibid.*, Principles 2 and 8, Guideline 8.
- 39 *Ibid.*, Guideline 2.
- 40 *Ibid.*, Guideline 6.
- 41 *Ibid.*, Clinical Guideline 11.
- 42 See George J. Annas, “Human Rights Outlaws: Nuremberg, Geneva, and the Global War on Terror,” *Boston University Law Review* 87 (2007): 427-466.
- 43 Johannes Wier Foundation for Health and Human Rights, *Assistance in hunger strikes: a manual for physicians and other health personnel dealing with hunger strikers* (Amersfoort: Johannes Wier Foundation, 1995).
- 44 International Council of Nurses, Position Statement, “The Nurses’ Role in the Care of Prisoners and Detainees” (1998), <http://www1.umn.edu/humanrts/instree/prisonerscare.html>.
- 45 International Council of Nurses, Policy Statement, “Nurses’ role in the care of detainees and prisoners” (2011), http://www.icn.ch/images/stories/documents/publications/position_statements/A13_Nurses_Role_Detainees_Prisoners.pdf.
- 46 UK Department of Health, *Guidelines for the clinical management of people refusing food in immigration removal centres and prisons* (August 2010), <http://www.globallawyersandphysicians.org/storage/UK%20Protocol.pdf>.
- 47 Karen Greenberg, *The Least Worst Place: Guantanamo’s First 100 Days* (New York: Oxford University Press USA, 2009), 185-187; Center for Constitutional Rights, *The Guantanamo Prisoner Hunger Strikes & Protests: February 2002-August 2005* (New York: Center for Constitutional Rights, September 2005).
- 48 Karen Greenberg, *The Least Worst Place* (2009), 187-188.
- 49 Center for Constitutional Rights, *The Guantanamo Prisoner Hunger Strikes & Protests: February 2002-August 2005* (2005).
- 50 It is not clear whether formal policies existed before 2003. The two policies discussed here are the first ones available to the Task Force. U.S. Department of Defense, Detention Hospital, Guantanamo Bay, Cuba, “SOP No: 001 Voluntary & Voluntary Total Fasting and Re-Feeding” (15 October 2003, revised August 2005), 1, http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/testimonies-of-standard-operating-procedures/forced_feeding_sop.pdf; U.S. Department of Defense, Joint Task Force - Guantanamo, Headquarters, “Camp Delta Standard Operating Procedures,” unclassified (28 May 2003), Chapter 19, Section III - Medical Problems, Hunger Strike; U.S. Department of Defense, Joint Task Force - Guantanamo, Headquarters, “Camp Delta Standard Operating Procedures,” unclassified (28 March 2004), Chapter 19, Section III - Medical Problems, Hunger Strike, 19.2, <http://www1.umn.edu/humanrts/OathBetrayed/SOP%201-238.pdf>. A hunger strike protocol referred to in the standard operating procedures has not been made available to the Task Force.
- 51 This requirement is contained in later policies and protocols, including a 2007 policy applicable to Camp Bucca in Iraq. U.S. Department of the Army, Headquarters, 705th Military Police Battalion, Camp Bucca, Iraq, “Memorandum for the Record, TIF SOP 107, Hunger Strike Procedures.” See also CJTF Detainee Standard Operating Procedure [Bagram] (no date [appears to be 2008]), Appendix 16 to Annex A, http://www.DoD.gov/pubs/foi/operation_and_plans/Detainee/ACLU_Bagram_Detention_CENTCOM_DocsI.pdf [hereafter cited as Bagram Hunger Strike Protocol].
- 52 U.S. Department of Defense, Joint Task Force - Guantanamo, Headquarters, “Camp Delta Standard Operating Procedures,” unclassified (28 May 2003), Chapter 19, Section III - Medical Problems, Hunger Strike; U.S. Department of Defense, Joint Task Force - Guantanamo, Headquarters, “Camp Delta Standard Operating Procedures,” unclassified (28 March 2004), Chapter 19, Section III - Medical Problems, Hunger Strike, 19.2, <http://www1.umn.edu/humanrts/OathBetrayed/SOP%201-238.pdf>. See also: U.S. Department of Defense, Detention Hospital, Guantanamo Bay, Cuba, “SOP No: 001 Voluntary & Voluntary Total Fasting and Re-Feeding” (2005), 4; Bagram Hunger Strike Protocol.
- 53 U.S. Department of Defense, Detention Hospital, Guantanamo Bay, Cuba, “SOP No: 001 Voluntary & Voluntary Total Fasting and Re-Feeding” (2005), 1. A 2007 policy applicable to Camp Bucca in Iraq is similar. U.S. Department of the Army, Headquarters, 705th Military Police Battalion, Camp Bucca, Iraq, “Memorandum for the Record, TIF SOP 107, Hunger Strike Procedures.” See also Bagram Hunger Strike Protocol.
- 54 The commander of the Joint Medical Group is the senior medical officer responsible for detainee medical care. The Joint Task Force commander is responsible for all detainee-related operations, including intelligence, detention management, and medical care.
- 55 Enteral feeding is described as follows in the 2009 report by Admiral Walsh: *Enteral feeding is the process of providing nutritional support for a patient by passing a tube through the nose into the stomach (a nasogastric feeding tube), through which nutritional supplements, such as Ensure Plus or Boost Plus, can be infused. This is a common medical procedure used to safely provide nutrition to a patient who is not taking food by mouth, but whose intestinal function is intact (e.g., a patient whose jaw is wired shut). The nasogastric tube used is size 10 or 12 French, which would be 3.5-4.5 millimeters in diameter (slightly larger in diameter than a piece of cooked spaghetti but less than a pencil eraser). The tube should be well lubricated (viscous lidocaine should be offered, but some patients prefer other lubricants). After insertion of the tube, its placement in the stomach is confirmed prior to allowing the nutritional supplement to flow in from a hanging bag by gravity. This procedure usually takes about an hour, after which the feeding tube is removed. Once stabilized, most patients can be sustained on two feedings per day.* Admiral Patrick Walsh, U.S. Department of Defense, Review of Department Compliance with President’s Executive Order on Detainee Conditions of Confinement (2009), 57, n. 50,

- http://www.defense.gov/pubs/pdfs/review_of_department_compliance_with_presidents_executive_order_on_detainee_conditions_of_confinementa.pdf [hereafter cited as Walsh Report (2009)].
- 56 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005), para. 14.
- 57 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005), 5, http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/testimony-of-military-physicians/edmondson_affidavit.pdf.
- 58 *Ibid.*, para. 10. A 2007 policy applicable to Camp Bucca in Iraq is similar. U.S. Department of the Army, Headquarters, 705th Military Police Battalion, Camp Bucca, Iraq, "Memorandum for the Record, TIF SOP 107, Hunger Strike Procedures."
- 59 *Ibid.*, para. 7. The Task Force did not have access to the entirety of the procedure, as there are significant redactions in the policy publicly released.
- 60 *Ibid.*, para. 15.
- 61 U.S. Department of Defense, Detention Hospital, Guantanamo Bay, Cuba, "SOP No: 001 Voluntary & Voluntary Total Fasting and Re-Feeding" (2005), 4, http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/testimonies-of-standard-operating-procedures/hunger_strike_sop.pdf p. 1 This policy was also followed at Bagram as of 2008. See also Bagram Hunger Strike Protocol [see note 51].
- 62 U.S. Department of Defense, Detention Hospital, Guantanamo Bay, Cuba, "SOP No: 001 Voluntary & Voluntary Total Fasting and Re-Feeding" (2005), 2.
- 63 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005), para. 15.
- 64 Tim Golden, "The Battle for Guantanamo," *New York Times Magazine* (17 September 2006), <http://www.nytimes.com/2006/09/17/magazine/17guantanamo.html?pagewanted=all>.
- 65 *Ibid.* See also Center for Constitutional Rights, *The Guantanamo Prisoner Hunger Strikes & Protests: February 2002-August 2005* (2005), 9.
- 66 Tim Golden, "The Battle for Guantanamo," *New York Times Magazine* (17 September 2006); Center for Constitutional Rights, *The Guantanamo Prisoner Hunger Strikes & Protests: February 2002-August 2005* (2005), 11.
- 67 Tim Golden, "The Battle for Guantanamo," *New York Times Magazine* (17 September 2006).
- 68 *Al-Joudi v. Bush*, 406 F. Supp. 2d 13, 15 and n. 1 (D.D.C. 2005). The DoD claimed that the number of hunger strikers peaked at 131 in September, 2005. Tim Golden, "Tough U.S. Steps in Hunger Strikes at Camp in Cuba," *New York Times* (9 February 2006), <http://www.nytimes.com/2006/02/09/politics/09gitmo.html?pagewanted=all>.
- 69 Susan Okie, "Glimpses of Guantanamo - Medical Ethics and the War on Terror," *New England Journal of Medicine* 353, no. 24 (2005): 2529-2534.
- 70 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005), para. 9.
- 71 Adam Zagorin, "At Guantanamo, Dying Is Not Permitted," *Time* (30 June 2006), <http://www.time.com/time/nation/article/0,8599,1209530,00.html>.
- 72 Supplementary Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-301 (GK) (D.D.C. 5 October 2005), <http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/prisoner-testimonies/supplemental-declaration-of-julia-tarver-october-13-2005>.
- 73 *Al-Joudi v. Bush*, 406 F. Supp. 2d 13, 16-17 (D.D.C. 2005).
- 74 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005). In Admiral Walsh's report, the claim was different: "Although new tubes are generally used the JMG SOP, which guides cleaning requirements for feeding tubes, has been reviewed and approved by the Infection Control Officer. Per manufacturer guidelines tubes may not be used for more than 14 days and are always used for only one detainee." Walsh Report (2009) [see note 57].
- 75 Supplementary Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-301 (GK) (D.D.C. 5 October 2005).
- 76 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005), para. 8 and 14.
- 77 *Al-Joudi v. Bush*, 406 F. Supp. 2d 13, 17 (D.D.C. 2005); Supplementary Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-301 (GK) (D.D.C. 5 October 2005), 6.
- 78 Susan Okie, "Glimpses of Guantanamo - Medical Ethics and the War on Terror," *New England Journal of Medicine* 353, no. 24 (2005): 2529-2534. There were suicides at Guantanamo, and mass suicide attempts, but these acts do not warrant the inference that hunger strikers were suicidal.
- 79 Eric Schmitt and Tim Golden, "Force-Feeding at Guantanamo is Now Acknowledged," *New York Times* (22 February 2006), <http://www.nytimes.com/2006/02/22/international/middleeast/22gitmo.html>.
- 80 Adam Zagorin, "At Guantanamo, Dying Is Not Permitted," *Time* (30 June 2006). Captain Sollock has died.
- 81 *Ibid.*
- 82 *Al-Adahi v. Obama*, 596 F. Supp. 2d 111 (D.D.C. 2009). Based on the government's representations, the court deemed it reasonable to implement security policies including the use of restraint chairs, though it did so under legal standards requiring significant deference to judgments of security and medical officials. The decision makes no reference to Captain Edmondson's declaration.
- 83 *Al-Adahi v. Obama*, 596 F. Supp. 2d 111, 115 (D.D.C. 2009). See also Tim Golden, "Tough U.S. Steps in Hunger Strikes at Camp in Cuba," *New York Times* (9 February 2006).
- 84 *Al-Adahi v. Obama*, 596 F. Supp. 2d 111, 121 (D.D.C. 2009).
- 85 Tim Golden, "The Battle for Guantanamo," *New York Times Magazine* (17 September 2006).
- 86 The Task Force had access to 2007 procedures from Camp Bucca in Iraq that reflect this policy of placing hunger strikers in isolation. U.S. Department of the Army, Headquarters, 705th Military Police Battalion, Camp Bucca, Iraq, "Memorandum for the Record, TIF SOP 107, Hunger Strike Procedures." See also Bagram Hunger Strike Protocol [see note 51]. The policy seems to have been in place at Guantanamo as well.
- 87 The original Declaration of Malta, from 1991, allows for "removal from the presence of fellow hunger strikers to avoid any peer pressure." That is not the same as keeping them in isolation.

- 88 Tim Golden, "Tough U.S. Steps in Hunger Strikes at Camp in Cuba," *New York Times* (9 February 2006).
- 89 Ibid.
- 90 Ibid.
- 91 Adam Zagorin, "At Guantanamo, Dying Is Not Permitted," *Time* (30 June 2006).
- 92 Ibid.
- 93 Adam Zagorin, "At Guantanamo, Dying Is Not Permitted," *Time* (30 June 2006).
- 94 Eric Schmitt and Tim Golden, "Force-Feeding at Guantanamo is Now Acknowledged," *New York Times* (22 February 2006).
- 95 Tim Golden, "Tough U.S. Steps in Hunger Strikes at Camp in Cuba," *New York Times* (9 February 2006). This position was also asserted by the government in court proceedings. *Al-Adahi v. Obama*, 596 F. Supp. 2d 111 (D.D.C. 2009).
- 96 Ibid.
- 97 Adam Zagorin, "At Guantanamo, Dying Is Not Permitted," *Time* (30 June 2006).
- 98 Tim Golden, "Tough U.S. Steps in Hunger Strikes at Camp in Cuba," *New York Times* (9 February 2006).
- 99 This later became official policy, at least at Bagram. See also George J. Annas, "Hunger Strikes at Guantanamo - Medical Ethics and Human Rights in a 'Legal Black Hole,'" *New England Journal of Medicine* 355, no. 13 (28 Sept 2006): 1377.
- 100 Ibid. See also Susan Okie, "Glimpses of Guantanamo - Medical Ethics and the War on Terror," *New England Journal of Medicine* 353, no. 24 (2005): 2529-2534.
- 101 Malta Declaration (2006), Guideline 7 [see note 18].
- 102 Report of Dr. Emily Keram, *Zuhair v. Obama*, Civ. No. 08-0864 (D.D.C. 28 April 2009), <http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/testimony-of-other-physicians/medical-and-psychiatric-evaluation-of-ahmed-zair-salim-zuhair>.
- 103 Eric Schmitt and Tim Golden, "Force-Feeding at Guantanamo is Now Acknowledged," *New York Times* (22 February 2006).
- 104 George J. Annas, "Hunger Strikes at Guantanamo - Medical Ethics and Human Rights in a 'Legal Black Hole,'" *New England Journal of Medicine* 355, no. 13 (28 Sept 2006): 1377.
- 105 Declaration of Richard G. Murphy, Jr., *Al-Adahi v. Bush*, Civ. No. 05-280 (GK) (D.D.C. 23 February 2006), 3-4; Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 20 September 2006), 4; Report of Dr. Emily Keram, *Zuhair v. Obama*, Civ. No. 08-0864 (D.D.C. 28 April 2009).
- 106 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005), 5.
- 107 Declaration by Marc D. Falkoff, *Shalabi v. Bush*, Civ. No. 05-0520 (RMU) (D.C.C. 7 March 2006), 2; Declaration of Richard G. Murphy, Jr., *Al-Adahi v. Bush*, Civ. No. 05-280 (GK) (D.D.C. 23 February 2006), 7; Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 20 September 2006), 5-6; Declaration of Thomas B. Wilner, *Al-Odah v. United States*, Civ. No. 02-0828 (CKK) (D.C.C. 29 September 2005), 8.
- 108 Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 20 September 2006), 6.
- 109 Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 20 September 2006); Declaration of Richard G. Murphy, Jr., *Al-Adahi v. Bush*, Civ. No. 05-280 (GK) (D.D.C. 23 February 2006), 3; Declaration by Marc D. Falkoff, *Shalabi v. Bush*, Civ. No. 05-0520 (RMU) (D.C.C. 7 March 2006), 2.
- 110 Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 20 September 2006).
- 111 Report of Dr. Emily Keram, *Zuhair v. Obama*, Civ. No. 08-0864 (D.D.C. 28 April 2009), 11.
- 112 "Petitioners motion to compel medical and psychiatric visits," *Al-Oshan v. Obama*, Civ. No. 05-0520 (RMU) (D.D.C. 10 September 2010).
- 113 Supplemental Declaration of Dr. Emily A. Keram, *Al-Oshan v. Obama*, Civ. No. 05-0520 (RMU) (D.D.C. 2 November 2009), <http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/testimony-of-other-physicians/supplemental-declaration-of-dr-emily-keram-on-abdul-rahman-shalabi/?searchterm=None>.
- 114 Report of Dr. Emily Keram, *Zuhair v. Obama*, Civ. No. 08-0864 (D.D.C. 28 April 2009), 11.
- 115 Supplementary Declaration of Julia Tarver, Esq., *Al-Joudi v. Bush*, Civ. No. 05-301 (GK) (D.D.C. 5 October 2005).
- 116 Declaration of Dr. Bruce Meneley, In Re: Guantanamo Bay Detainee Litigation, Civ. No. 04-1254 (HHK) (D.D.C. 25 August 2008), <http://docs.justia.com/cases/federal/district-courts/district-of-columbia/dcdce/1:2008mc00442/131990/346/1.pdf>.
- 117 *Al-Adahi v. Obama*, 596 F. Supp. 2d 111 (D.D.C. 2009). The court also rejected the claims on jurisdictional grounds and stated the use of the restraint chair did not amount to cruel and unusual punishment because the legal standard required the officials to act with "deliberate indifference" to detainees' health needs. As discussed below, however, the court did accept the DoD's arguments that they were concerned with saving the lives of the detainees and there was no less restrictive alternative possible.
- 118 David Nicholl and others, Letter, "Forcefeeding and restraint of Guantanamo Bay hunger strikers," *The Lancet* 367 (2006): 811.
- 119 Letter from Karin Moran, American Medical Association, to William Hopkins and Sherman Carroll, Medical Foundation for Victims of Torture (15 March 2006); American Medical Association, "AMA Reiterates Opposition to Feeding Individuals Against Their Will," *American Medical News* (10 March 2006).
- 120 Kevin B. O'Reilly, "Physicians speak out on prisoner force-feeding," *American Medical News* (3 April 2006), <http://www.ama-assn.org/amednews/2006/04/03/prsc0403.htm>.
- 121 Islamic Medical Association of North America, "IMANA statement on the question of forced feeding of hunger-striking detainees in US custody" (5 November 2007), <http://www.imana.org/?page=hungerstriking>.
- 122 UN General Assembly, Resolution 37/194, "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” (18 December 1982), Principle 5, <http://www.un.org/documents/ga/res/37/a37r194.htm>.
- 123 U.S. Department of Defense, Instruction 2310.08E, “Medical Program Support for Detainee Operations” (6 June 2006), para. 4.7.1. This was the same policy that sought to justify the ethical propriety of participation of physicians and psychologists in behavioral science consultation teams.
- 124 U.S. Department of Defense, Instruction 2310.08E, “Medical Program Support for Detainee Operations” (6 June 2006).
- 125 See George J. Annas, “Military Medical Ethics - Physician First, Last, Always,” *New England Journal of Medicine* 359 (2008):1087-1090.
- 126 U.S. Department of Defense, Instruction 2310.08E, “Medical Program Support for Detainee Operations” (6 June 2006), para. 4.1.6.
- 127 Report of Dr. Emily Keram, *Zuhair v. Obama*, Civ. No. 08-0864 (D.D.C. 28 April 2009), <http://humanrights.ucdavis.edu/projects/the-guantanamo-testimonials-project/testimonies/testimony-of-other-physicians/medical-and-psychiatric-evaluation-of-ahmed-zair-salim-zuhair>.
- 128 U.S. Department of Justice, Federal Bureau of Prisons, “Program Statement P5562.05: Hunger Strikes (29 July 2005), 1-8, http://www.bop.gov/policy/progstat/5562_005.pdf.
- 129 Mike Baker, AP Features, “Federal prison to start force-feeding Palestinian whose hunger strike has lasted 6 weeks,” *Bay Ledger* (7 March 2007), http://www.blz.com/news/2007/03/07/Federal_prison_start_force-feeding_Palestinian_cr_s.html.
- 130 “Use of Force and Application of Restraints on Inmates - Purpose and Scope,” *U.S. Code of Federal Regulations* 28 (2010), § 552.20.
- 131 There may be one exception. In response to a 2007 request from Human Rights Watch for information concerning practices at federal supermax prison ADX Florence, which houses individuals convicted of terrorism and other offenses, the Bureau of Prisons stated that response to hunger strikes was governed by Program Statement P5562.05, cited in note 130 above. Letter from Kathleen Kenney, Assistant Director/General Counsel, Bureau of Prisons, to Jennifer Daskal, Human Rights Watch (9 April 2007) [on file with the Task Force]. In a subsequent visit to the facility, Human Rights Watch was told by inmates that they were subject to retaliation for using hunger strikes by being denied mattresses, water in cells, and toiletries, and subjected to the use of punitive and painful restraint chairs. Staff responded that inmates were placed in restraints only for short periods before feeding took place. Letter from Jamie Fellner and Jennifer Daskal to Harley Lapin (2 May 2007) [on file with the Task Force].
- 132 United States of America, *Second Periodic Report of the United States of America to the Committee Against Torture* (6 May 2005), para. 35, <http://www1.umn.edu/humanrts/cat/us-staterreport2005.html>.
- 133 “Use of Four-Point Restraints,” *U.S. Code of Federal Regulations* 28 (2010), § 552.24.
- 134 See U.S. Department of Justice, Federal Bureau of Prisons, “Program Statement P5562.05: Hunger Strikes (29 July 2005), 7; Leonard S. Rubenstein and George J. Annas, “Medical ethics at Guantanamo Bay detention center and in the US military: a time for reform,” *The Lancet* 374 (2009): 353-355.
- 135 U.S. Department of Justice, Federal Bureau of Prisons, “Program Statement P5562.05: Hunger Strikes (29 July 2005), para. 8 [7 also cited], http://www.bop.gov/policy/progstat/5562_005.pdf.
- 136 *Ibid.*, para. 7.
- 137 *Ibid.*, para. 8.
- 138 Luke Mitchell, “Six Questions for Cynthia Smith on the Legality of Force-feeding at Guantanamo,” *The Stream, Harper’s Magazine* (4 June 2009), <http://harpers.org/archive/2009/06/hbc-90005110>.
- 139 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005).
- 140 U.S. Department of Defense, “Media Roundtable with Assistant Secretary Winkenwerder,” news transcript (7 June 2006), <http://www.defenselink.mil/transcripts/transcript.aspx?transcriptID=33>.
- 141 UN General Assembly, Resolution 37/194, “Principles of Medical Ethics” (1982).
- 142 Islamic Medical Association of North America, “IMANA statement on the question of forced feeding of hunger-striking detainees in US custody” (5 November 2007).
- 143 One of the authors of this chapter was also co-author of the background paper, together with the British Medical Association.
- 144 *Al-Adahi v. Obama*, 596 F. Supp. 111, 121 (D.D.C. 2009).
- 145 *Ibid.*
- 146 The document is part of a set of documents released under the Freedom of Information Act: Bagram Hunger Strike Protocol, Appendix 16 to Annex A and Tab F [see note 51]. Although the specific date of this document is unclear, it is clear from the references that it was released after October 2006.
- 147 Declaration of Dr. Bruce Meneley, In Re: Guantanamo Bay Detainee Litigation, Civ. No. 04-1254 (HHK) (D.D.C. 25 August 2008).
- 148 Bagram Hunger Strike Protocol, 000106. In 2012, a Pentagon spokesman similarly recognized hunger strikes as a form of non-violent protest and that those few who engage in this practice are monitored so that their health is never in any real danger. See <http://www.foxnews.com/politics/2012/03/13/two-11-suspects-reportedly-on-gitmo-hunger-strike/>.
- 149 The protocol classifies a hunger striker as someone who refuses meals for 72 hours or has missed nine consecutive meals. At that time, after notifying the chain of command, the detainee is evaluated medically and psychologically. In accordance with good medical practice, if a detainee is determined to be suffering from a mental disorder, he is referred for treatment of the disorder.
- 150 Bagram Hunger Strike Protocol, 000108.
- 151 *Ibid.*
- 152 *Ibid.*, 000106, 000108.
- 153 *Ibid.*, 000109-10.

- 154 Ibid., 000120.
- 155 Declaration of Dr. Bruce Meneley, In Re: Guantanamo Bay Detainee Litigation, Civ. No. 04-1254 (HHK) (D.D.C. 25 August 2008).
- 156 *Al-Adahi v. Obama*, 596 F. Supp. 111, 121 (D.D.C. 2009).
- 157 Carol Rosenberg, "10 Percent of Guantanamo detainees now being force fed," *Miami Herald* (8 January 2009), <http://www.mcclatchydc.com/2009/01/08/59284/10-percent-of-guantanamo-detainees.html>.
- 158 Walsh Report (2009), 57 [see note 57].
- 159 Ibid.
- 160 Ibid., 58.
- 161 Ibid., 56.
- 162 The DoD and the Walsh Report do not indicate how many detainees have been subjected to the use of the restraint chair. This question bears investigation.
- 163 Irom Chanu Sharmila of India, who has been on a hunger strike for more than a decade. Lydia Polgreen, "In India, 11-Year Hunger Strike over Military Violence is Waged in Shadows," *New York Times* (11 September 2011), http://www.nytimes.com/2011/09/11/world/asia/11manipur.html?_r=1&scp=1&sq=polgreen%20hunger%20strike&st=cse. It does not appear, though, that she is subjected to physical restraints in the process.
- 164 Jason Leopold, "Guantanamo Detainees Stage Hunger Strike to Protest Confinement Conditions," *Truthout* (29 April 2011), <http://www.truthout.org/guantanamo-detainees-hunger-strike-protest-confinement-conditions/1304092655>.
- 165 Catherine Herridge, "Two 9/11 suspects on hunger strikes, sources say," *Fox News* (14 March 2012), <http://www.foxnews.com/politics/2012/03/13/two-11-suspects-reportedly-on-gitmo-hunger-strike/>.
- 166 Joint Task Force - Guantanamo, Joint Medical Group, "Standard Operating Procedure: Medical Management of Detainees on Hunger Strike," (5 March 2013), <http://www.aljazeera.com/humanrights/2013/05/201358152317954140.html>.
- 167 Declaration of John Edmondson, *Al-Joudi v. Bush*, Civ. No. 05-0301 (GK) (D.D.C. 19 October 2005), para. 15.
- 168 Charlie Savage, "Number of Hunger Strikers Surges at Guantanamo," *New York Times* (20 March 2013), <http://www.nytimes.com/2013/03/21/us/hunger-strike-cases-surge-at-guantanamo.html>.
- 169 Carol Rosenberg, "White House monitoring hunger strikes," *Miami Herald* (28 March 2013), <http://www.miamiherald.com/2013/03/27/3309986/white-house-monitoring-guantanamo.html>.
- 170 Matt Spetalnick, "Red Cross chief presses U.S. on Guantanamo hunger strike," *Reuters* (11 April 2013), <http://www.reuters.com/article/2013/04/11/us-usa-guantanamo-redcross-idUSBRE93A10J20130411>.
- 171 Carol Rosenberg, "Troops forcibly move hunger strikers into cells," *Miami Herald* (14 April 2013), <http://www.miamiherald.com/2013/04/13/3342104/troops-forcibly-move-hunger-strikers.html>.
- 172 Samir Naji Al Hasan Moqbel, "Gitmo Is Killing Me," Op-Ed Contributor, *New York Times* (14 April 2013), <http://www.nytimes.com/2013/04/15/opinion/hunger-striking-at-guantanamo-bay.html>.
- 173 Letter from Jeremy A. Lazarus, President, American Medical Association, to Chuck Hagel, U.S. Secretary of Defense (25 April 2013), <https://www.documentcloud.org/documents/694196-hunger-strikers-letter-04-25-13.html>.
- 174 Susan Mayor, "AMA calls for inquiry into doctors' role in abuse of prisoners," *British Medical Journal* 329 (2004): 993; Charlie Savage, "Amid Hunger Strike, Obama Renews Push to Close Cuba Prison," *New York Times* (30 April 2013), http://www.nytimes.com/2013/05/01/us/guantanamo-adds-medical-staff-amid-hunger-strike.html?hp&_r=0.
- 175 *Ciorap v. Moldova*, App. No. 12066/02, Eur. Ct. H.R. (19 June 2007).
- 176 Scott A. Allen and Hernán Reyes, "Clinical and Operational Issues in the Medical Management of Hunger Strikers" in *Interrogation, Forced Feedings and the Role of Health Professionals*, ed. Goodman and Roseman (2009).
- 177 George J. Annas, "American Vertigo: 'Dual Use,' Prison Physicians, Research, and Guantanamo," *Case Western Reserve Journal of International Law* 43 (2011): 631-650. National medical associations need to provide support for physicians confronted to such ethical dilemmas, and if necessary appeal to supra-national entities such as the World Medical Association for guidance.
- 178 If security procedures require a guard's presence within earshot or if there are microphones or other devices to monitor conversations, the physician should be transparent and tell the hunger striker that he, the doctor, is not in a position to impose their removal.
- 179 Malta Declaration (2006), Clinical Guidelines 9 and 10 [see note 18].
- 180 International Committee of the Red Cross, *Geneva Conventions* (1949), Common Article 3; United Nations, *Standard Minimum Rules for the Treatment of Prisoners* (1977), <http://www1.umn.edu/humanrts/instree/g1smr.htm>.
- 181 Marine Brig. Gen. Michael Lehnert, commander of the Guantanamo detention mission said that the detainees' underlying concern is uncertainty over their indefinite detention. "Military says all but 13 prisoners at Guantanamo have eaten since beginning of hunger protest," *Associated Press* (3 March 2002), http://www2.ljworld.com/news/2002/mar/03/military_says_all/?print.

CHAPTER 4

- 1 Physicians for Human Rights and University of Cape Town Health Sciences Centre, Dual Loyalty Working Group, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* (Boston: Physicians for Human Rights and University of Cape Town, March 2003), <http://physiciansforhumanrights.org/library/reports/dual-loyalty-and-human-rights-2003.html>.
- 2 Lisa Soleymani Lehmann and others, "A Survey of Medical Ethics Education at U.S. and Canadian Medical Schools," *Academic Medicine* 79, no. 7 (2004): 682-689.

- 3 L. Emily Cotter and others, "Health and Human Rights Education in U.S. Schools of Medicine and Public Health: Current Status and Future Challenges" *PLoS ONE* 4, no. 3 (2009): e49116.
- 4 Uniformed Services University of the Health Sciences was established by an Act of Congress in 1972 (PL 92-426). The statute mandated the creation of the university, under the DoD, within 25 miles of the District of Columbia, and mandated the graduation of no less than 100 medical students annually. Although the statute was passed in 1972, the medical school did not begin admitting students until 1976, when it received provisional accreditation as a four-year medical school from the Liaison Committee on Medical Education, the accrediting body for all U.S. medical schools. It received full accreditation in 1980, in which year the first class, with 29 students, graduated.
- 5 Uniformed Services University of the Health Sciences, Catalog 2008-2010.
- 6 This number should be compared with 34.8% of those who had received their medical education in civilian medical schools under the Health Professions Scholarship Program. Daniel L. Cohen and others, "Longer-Term Career outcomes of Uniformed Services University of the Health Sciences Medical School Graduates: Classes of 1980-1989," *Military Medicine* 173, no. 5 (2008): 422.
- 7 Ibid.
- 8 Edmund G. Howe, "Mixed Agency in Military Medicine: Ethical Roles in Conflict" in *Military Medical Ethics*, Vol. 1 (Washington, DC: Borden Institute, 2003), 333-335.
- 9 Michael L. Gross, "Bioethics and Armed Conflict: Mapping the Moral Dimensions of Medicine and War," *Hastings Center Report* 34, no. 6 (2004): 22-30.
- 10 Thomas Beam, "Medical Ethics on the Battlefield: The Crucible of Military Medical Ethics" in U.S. Department of the Army, office of the Surgeon General, *Military Medical Ethics*, vol. 2 (2003); Sessums and others, "Ethical Practice Under Fire: Deployed Physicians in the Global War on Terrorism," *Military Medicine* 174, no 5. (2009): 441-447.
- 11 The National Naval Medical Center (Army and Navy) offers internal medicine, surgery, and pediatric residencies; the San Antonio Military Medical Center (Army and Air Force) offers internal medicine, surgery, ob/gyn, pediatrics, and emergency medicine residencies. Also included are the military medical centers in Hawaii (Tripler, which is Army and has internal medicine, surgery, ob/gyn, and pediatric residencies), San Diego (Naval Medical Center, has internal medicine, surgery, ob/gyn, pediatrics, and emergency medicine residencies), Fort Gordon Georgia (Eisenhower Medical Center, which is Army and has only internal medicine and surgery residencies), Keesler Mississippi (Keesler Medical Center, which is Air Force and has internal medicine and surgery residencies), Virginia (Portsmouth Naval Medical Center, which has internal medicine, surgery, ob/gyn, pediatric, and emergency medicine residencies), and Washington State (Madigan Army Medical Center, which has internal medicine, surgery, ob/gyn, pediatric, and emergency medicine residencies).
- 12 U.S. Army Directorate of Medical Education, <http://www.mods.army.mil/medicaleducation/>. Included in this group are also physicians in the Reserve Officer's Training Corps (ROTC) Medical Delay Program (those who enrolled in RoTC, then decided to attend medical school and wish to complete residency training before serving in the army) and the Health Professions Loan Repayment Program (medical students with loans who did not enroll in the Health Professions Scholarship Program while in medical school but decide to serve in the military after graduation in exchange for loan repayments).
- 13 Sessums and others, "Ethical Practice Under Fire: Deployed Physicians in the Global War on Terrorism," *Military Medicine* 174, no 5. (2009): 441-447.
- 14 Colonel Telita Crosland (Senior Medical Officer, Health Policy and Services Directorate, Offices of Army and Surgeon General) in conversation with the author.
- 15 International Committee of the Red Cross, *Geneva Convention (III) relative to the Treatment of Prisoners of War* (12 August 1949), Article 4.
- 16 Ibid., para. 93.
- 17 Ibid., para. 247.
- 18 International Committee of the Red Cross, *Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War* (12 August 1949), Article 78.
- 19 U.S. Department of the Army, Headquarters, FM 27-10, *The Law of Land Warfare* (July 1956), paras. 433, 442, 443, 446, <http://www.afsc.army.mil/gc/files/fm27-10.pdf>.
- 20 Ibid., paras. 270, 271.
- 21 U.S. Department of the Army, Headquarters, FM 6-22 (formerly FM 22-100), *Army Leadership: Competent, Calm and Agile* (October 2006).
- 22 U.S. Department of the Army, Office of the Surgeon General, *Final Report: Assessment of Detainee Medical Operations for OEF, GTMO, and OIF* (2005), sec. 6-1, http://www.globalsecurity.org/military/library/report/2005/detmedopsrpt_13apr2005.pdf.
- 23 Ibid., secs. 6-7, 8-1, 8-2.
- 24 Ibid., secs. 9-1, 9-2.
- 25 Ibid.
- 26 Ibid., sec. 6-13.
- 27 Ibid., sec. 8-4.
- 28 Ibid., sec. 6-15. The manual was written in 2001 and is available at https://s3.amazonaws.com/PHR_Reports/examining-asylum-seekers-manual.pdf.
- 29 U.S. Department of Defense, Instruction 2310.08E, "Medical Program Support for Detainee Operations" (6 June 2006), <http://www.dtic.mil/whs/directives/corres/pdf/231008p.pdf>.
- 30 See <http://www.ncosupport.com/military-training/detainee-operations.html>. The course is not available to the public.
- 31 U.S. Department of the Army, Headquarters, U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 21; U.S. Department of the Army, Headquarters, U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2009), 21.
- 32 OTSG/MEDCOM Policy Memo 13-027, "US Army Behavioral Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning," (2012), 16-18; OTSG/MEDCOM Policy Memo 09-053, "US Army Behavioral

Science Consultation to Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning,” (2009), 16-18.

CHAPTER 5

- 1 In the military law context, health professionals can be held accountable under the provisions of the Uniform Code of Military Justice. Criminal prosecution through civilian courts would be appropriate in cases of torture under 18 U.S.C. §§ 2340-2340A. In such cases, where misconduct rises to the level of criminal conduct, the Department of Justice ought to exercise its authority to pursue violators for crimes alongside military credentialing and state boards’ authority to pursue them for professional misconduct. Enforcing the criminal law against military and intelligence health professionals where appropriate would reassure state boards of the existence of political will to sanction ethical misconduct. Conversely, when the Department of Justice fails to act against health professionals in those cases, state boards may be reluctant to apply disciplinary sanctions. At minimum, the Department of Justice ought to make clear to the state boards that its inaction in no way limits the state boards’ ability to discipline professional misconduct. Furthermore, it should refer cases that may not rise to the level of torture under federal law to the state boards for evaluation under the standards for professional conduct.

Torture is considered a serious international crime that attracts universal jurisdiction. Under international law, the perpetrator may be prosecuted by any state, whether or not that state is connected with the perpetrator, the victim, or the location of the crime. For a discussion of universal jurisdiction, including its supporting rationales and objections, see, e.g., Stephen Macedo, ed., *Universal Jurisdiction: National Courts and the Prosecution of Serious Crimes Under International Law* (Philadelphia: University of Pennsylvania Press, 2004); Jonathan H. Marks, “Mending the Web: Universal Jurisdiction, Humanitarian Intervention and the Abrogation of Immunity by the Security Council,” *Columbia Journal of Transnational Law* 42 (2004): 445-490.

- 2 Military and intelligence health professionals may also become defendants in civil suits for damages brought by or on behalf of detainees. To date, however, U.S. courts have failed to recognize the right of non-U.S. citizen survivors of torture in post-9/11 conflicts to seek civil redress for torture that was perpetrated by U.S. officials in offshore military and intelligence facilities.
- 3 Social accountability measures, which can take a variety of forms, are more likely to emerge where formal accountability mechanisms are unresponsive. See, e.g., When Healers Harm, <http://whenhealersharm.org/>.
- 4 Although we focus on state disciplinary board proceedings, we recognize that these are not the only available professional mechanisms for discipline. Some voluntary health professional associations have internal disciplinary mechanisms that, if used against a health professional, might have serious implications, especially if the health professional’s employer or the laws of the state in which she is licensed requires health professionals to be in good standing with that association. However, professional associations’ power to sanction is usually limited to their own members, and many health professionals are not members of these associations.
- 5 See chapter 2. U.S. Department of Defense, HA Policy 99-007, “Policy on Physician Licensure,” http://www.health.mil/libraries/HA_Policies_and_Guidelines/99-007.pdf; U.S. Department of Defense, Instruction 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)” (17 February 2011), <http://www.dtic.mil/whs/directives/corres/pdf/602513p.pdf>.
- 6 On historical antecedents, see e.g., Steven H. Miles, “Doctors’ complicity with torture,” Editorial, *British Medical Journal* 337 (31 July 2008), 1088.
- 7 See appendix 4.
- 8 The problem of health professional complicity in prisoner abuse is not limited to the military and intelligence spheres; some of these recommendations might be applicable to addressing analogous problems that arise in domestic law enforcement and immigration contexts. However, these considerations are beyond the scope of this Task Force report.
- 9 We use the word “prisoner” to convey the scope of reforms the Task Force proposes. We use the term not in a technical or legal sense, but to describe broadly the group of people whose liberty has been taken away and to whom protections should apply.
- 10 See, e.g., International Center for Transitional Justice, *Accountability in Argentina: 20 Years Later, Transitional Justice Maintains Momentum* (New York: International Center for Transitional Justice, August 2005), <http://ictj.org/sites/default/files/ICTJ-Argentina-Accountability-Case-2005-English.pdf>.
- 11 Steven H. Miles, Telma Alencar, and Brittney N. Crock, “Punishing Physicians Who Torture: A Work in Progress,” *Torture* 20 (2010): 23-31.
- 12 Licensed health professionals are defined in each state law but generally include those with specialized training and degrees, such as physicians, psychologists, nurses, physical therapists, dentists, social workers, optometrists and many others. See, e.g., Federation of State Medical Boards, *State of the States 2009: Report on Physician Regulation* (Eules, TX: Federation of State Medical Boards, 2009); Randall R. Bovbjerg and Pablo Aliaga, U.S. Department of Health & Human Services, “State Discipline of Physicians: Assessing State Medical Boards Through Case Studies” (2006), 33, 35 [hereafter cited as Bovbjerg 2006]; Association of State and Provincial Psychology Boards, “Frequently Asked Questions Regarding Disciplinary Action,” accessed July 2013, <http://www.asppb.net/i4a/pages/index.cfm?pageid=3499>.
- 13 Federation of State Medical Boards, *State of the States 2009* (2009), 5.
- 14 Bovbjerg 2006, 8.
- 15 Federation of State Medical Boards, *State of the States 2009* (2009), 19.
- 16 Nadia N. Sawicki, “Character, Competence, and the Principles of Medical Discipline,” *Journal of Health Care Law and Policy* 13 (2010), at 295 [hereafter cited as Sawicki 2010]: “... the primary goal of (and justification for) professional discipline is public protection. As an extension of the state’s police power, the medical board’s disciplinary authority is aimed at protecting medical consumers from the harms they may incur at the hands of incompetent or dishonest physicians. This is reflected in the sanctions that may be imposed on physicians, which range from alerting the medical board and community of a potential for harm (via a public letter of reprimand) to withdrawing the physician’s right to practice (delicensure). Unlike criminal law, which is aimed at punishing wrongdoers, or civil law, which is aimed at victim compensation, professional discipline seeks to protect public welfare by incapacitating or rehabilitating dangerous physicians.”
- 17 Federation of State Medical Boards, *State of the States 2009* (2009), 19; Association of State and Provincial Psychology Boards, “Frequently Asked Questions”; Sawicki 2010, 293.
- 18 Sawicki 2010, 293.
- 19 Sawicki 2010, 292-93.

20 Harris S. Cohen, "Professional Licensure, Organizational Behavior, and the Public Interest," *Milbank Memorial Fund Quarterly: Health and Society* 51 (1973), 76-80.

21 Edmund Pellegrino and Arnold Relman, "Professional Medical Associations: Ethical and Practical Guidelines," 282 *JAMA* 282 (1999), 984-986. See also David Rothman and others, "Professional Medical Associations and Their Relationships with Industry," *JAMA* 301 (2009), 1367-1372.

22 For example, the Alabama Board of Examiners in Psychology adopts the American Psychological Association Code of Ethics and the Rhode Island Board of Medical Licensure and Discipline treats the American Medical Association Code of Ethics as the legal standard. Similarly, in Ohio, the American Psychological Association and CPA ethics codes and standards are "used as aids in resolving ambiguities that may arise in the interpretation of the rules of professional conduct...." See *Ohio Revised Code* 4732.17.

23 See, e.g., Justine Sharrock, "First, Do Harm," *Mother Jones* (July/August 2009), 60-63; Luke Mitchell, "The Ongoing Medicalization of Torture," *The Stream, Harper's Magazine* (1 August 2007), <http://harpers.org/archive/2007/08/hbc-90000688>.

24 See, e.g., American Medical Association, Code of Medical Ethics, "Frequently Asked Questions in Ethics," accessed July 2013, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/frequently-asked-questions.page>: "...the AMA is not in a position to investigate allegations of unprofessional or unethical conduct at the local level. Instead, we defer to state medical societies and national specialty societies to conduct fact finding investigations when such allegations are made."

25 Letter from the American Psychological Association to Texas State Board of Examiners of Psychologists, Re: Complaint filed by Dr. Jim L. H. Cox regarding Dr. James Elmer Mitchell (30 June 2010), <http://www.apa.org/news/press/statements/texas-mitchell-letter.pdf>.

26 See Stanley J. Gross, "The Myth of Professional Licensing," *American Psychologist* 33 (1978), 1009. He argues, for example, that health professionals have lobbied for the creation of state boards "to secure public confidence and a monopoly of skill."

27 See, e.g., Kevin B. O'Reilly, "Medical board could discipline physicians for torture under N.Y. bill," *American Medical News* (10 June 2011), <http://www.ama-assn.org/amednews/2011/06/06/prsd0610.htm>. He suggests that "the matter is best handled at the federal level" rather than through state laws. Bovbjerg 2006, 33 [see note 14], notes the "frustration" expressed by board members that the current disciplinary process "was not finding enough of what might be termed 'problem physicians' or not finding them soon enough."

28 See chapter 2.

29 Sawicki 2010, 293.

30 For example, some states give boards independence, broad powers, and discretion; others place boards under the supervision of larger administrative agencies. A few limit a board's function to that of advisory bodies. Some states even vest licensing and disciplinary functions in two different boards. See Federation of State Medical Boards, *Elements of a Modern State Medical and Osteopathic Board* (Euleless, TX: Federation of State Medical Boards, May 2009), 4.

31 See, e.g., Federation of State Medical Boards, *The Essentials of a Modern Medical and Osteopathic Practice Act* (Euleless, TX: Federation of State Medical Boards, 2010); American Psychological Association, *Model Act for State Licensure of Psychologists* (Washington, DC: American Psychological Association, 2010), <http://www.apa.org/about/policy/model-act-2010.pdf>.

32 See New York State Assembly, Bill No. A5891A (2 March 2011); New York State Senate, Bill No. S6795-2011 (22 March 2012).

33 See UN General Assembly, Resolution 45/110, "United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules)" (14 December 1990); UN General Assembly, Resolution 37/194, "Principles of Medical Ethics" (1982), <http://www.un.org/documents/ga/res/37/a37r194.htm>; World Medical Association, *WMA Regulations in Times of Armed Conflict and Other Situations of Violence* (1956; revised Bangkok: WMA General Assembly, October 2012), <http://www.wma.net/en/30publications/10policies/a20/index.html>; American Medical Association, Code of Medical Ethics, Opinion 2.068, "Physician Participation in Interrogation" (2006), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2068.page>; "American College of Physicians Ethics Manual, Fifth Edition," *Annals of Internal Medicine* 142, no. 7 (2005): 560-582, <http://annals.org/article.aspx?articleid=718312>; American Psychological Association, "APA Ethics Committee Statement — No Defense to Torture" (June 2009), <http://www.AmericanPsychologicalAssociation.org/ethics/programs/statement/torture-code.aspx>.

34 See, e.g., Kevin Drum, "Defining Torture Down," *Mother Jones* (16 April 2009), <http://motherjones.com/kevin-drum/2009/04/defining-torture> by the OLC Torture Memorandum," *Journal of National Security Law and Policy* 1 (2005), 455.

35 Letter from Louis J. Catone to Kathy Roberts, Esq., Center for Justice & Accountability (July 28, 2010), 2.

36 See appendix 4.

37 In the context of the death penalty, professional responsibilities also extend to activities

that are not within the scope of activities to improve a patient's well-being. Deborah W. Denno, "The Lethal Injection Quandry: How Medicine Has Dismantled the Death Penalty," *Fordham Legal Review* 76 (2007), 49; Nadia N. Sawicki, "Doctors, Discipline, and the Death Penalty: Professional Implications of Safe Harbor Policies," *Yale Law and Policy Review* 27 (2008), 107.

38 However, this does not preclude physicians from serving as independent monitors to prevent torture. See, e.g., World Medical Association, "The Role of Physicians in the Prevention of Torture," accessed July 2013, <http://www.wma.net/en/20activities/20humanrights/40torture/>: "The WMA believes that the participation of physicians in these visiting mechanisms is essential to address health issues related to cruel, inhuman, or degrading treatment, to evaluate the health system and to assess the impact of general conditions of detention on the health of detained population."

39 See Physicians for Human Rights and University of Cape Town Health Sciences Centre,

Dual Loyalty Working Group, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* (Boston: Physicians for Human Rights and University of Cape Town, March 2003), <http://physiciansforhumanrights.org/library/reports/dual-loyalty-and-human-rights-2003.html>; Eric Stover and Elena O. Nightingale, *The Breaking of Bodies and Minds* (New York: W. H. Freeman & Co., Ltd., 1985).

40 See also Leonard Rubenstein, "Symposium Guantanamo: How Should We Respond? First,

Do No Harm: Health Professionals and Guantanamo," *Seton Hall Law Review* 37 (2007), 733: "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."

- 41 It should be noted, however, that under American Medical Association and American Psychiatric Association standards, a prohibition on health professional participation in interrogation does not preclude health professionals from providing general training and instruction to interrogators. According to these standards, so long as the instruction is not in relation to a specific interrogation and does not include methods intended to cause the subjects harm, licensed health professionals can provide interrogation training without compromising their proper role as a healer. It would also still permit fully independent monitoring of interrogations by health professionals.
- 42 Similarly, medical schools train their students to be healing professionals. See Audiey C. Kao and Kayhan P. Parsi, "Content Analyses of Oaths Administered at U.S. Medical Schools in 2000," *Academic Medicine* 79, no. 9 (2004), 882-887: "Among the schools that used a modification of the Hippocratic Oath, most administered oaths that explicitly stated the importance for physicians to act with beneficence (78%); Ana Maria Rancich and others, "Beneficence, justice, and lifelong learning expressed in medical oaths," *Journal of Continuing Education in the Health Professions* 25 (YEAR), 211: "most (75%) of the analyzed oaths express the principle of beneficence".
- 43 See American Medical Association, Report of the Council on Ethical and Judicial Affairs, "CEJA Report 10-A-06: Physician Participation in Interrogation" (Chicago: American Medical Association, 2006), <http://www.ama-assn.org/resources/doc/code-medical-ethics/2068a.pdf>: "physician involvement could also lead to the belief on the part of interrogators that they can escalate the use of force until the physician intervenes."
- 44 This broad definition is derived from recognized international standards on detained and imprisoned persons. See United Nations, *Standard Minimum Rules for the Treatment of Prisoners* (1977), <http://www1.umn.edu/humanrts/instreet/g1smr.htm> (applicable to "all categories of prisoners, criminal or civil, untried or convicted, including prisoners subject to 'security measures' or corrective measures ordered by the judge"); UN General Assembly, Resolution 43/173, "UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment," (9 December 1988), <http://www.un.org/documents/ga/res/43/a43r173.htm> (standards are applicable to any person deprived of personal liberty as a result of conviction for an offence or for any other reason).
- 45 These provisions would not affect the authority of health professional to consult on restraints used on the prisoner for his or her own safety or for the safety of others, subject to standards on the use of such restraints.
- 46 The World Medical Association considers it "unethical" for physicians to engage in tasks that do not preserve health or save lives, including "weaken the physical or mental strength of a human being without therapeutic justification; employ scientific knowledge to imperil health or destroy life, employ personal health information to facilitate interrogation, [and] condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment." World Medical Association, *WMA Regulations in Times of Armed Conflict and Other Situations of Violence* (1956; revised Bangkok: WMA General Assembly, October 2012), <http://www.wma.net/en/30publications/10policies/a20/index.html>.
- 47 American Medical Association, "Principles of Medical Ethics VIII" (Chicago: American Medical Association, 1957; revised 2001), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>: "A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law"; American Medical Association, Code of Medical Ethics, Opinion 5.05, "Confidentiality" (1983), <http://www.ama-assn.org/> ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion505.page: "The information disclosed to a physician by a patient should be held in confidence. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations."
- 48 Annette L. Hanson, "Confidentiality in corrections: fact or fiction?," *AAPL Newsletter* 24, no 3. (1999), 8, http://www.aapl.org/newsletter/N243Confidentiality_corrections.htm.
- 49 45 C.F.R. § 164.512(f); 45 C.F.R. § 164.512(k).
- 50 See Annette L. Hanson, "Confidentiality in corrections: fact or fiction?," *AAPL Newsletter* 24 (1999), 8, http://www.aapl.org/newsletter/N243Confidentiality_corrections.htm. The National Commission on Correctional Health Care views confidential medical treatment as an important standard for accreditation. Specifically, it states: "Health care encounters are private, with a chaperone present when indicated, and are carried out in a manner designed to encourage the patients' subsequent use of health services. Clinical encounters should be conducted in private and not observed by security personnel unless the inmate poses a probable risk to the safety of the health care provider."; Emil R. Pinta, "Decisions to Breach Confidentiality When Prisoners Report violations of Institutional Rules," *Journal of the American Academy of Psychiatric Law* 37 (2009), 154: "As a general principle, standards of care in prisons, including patient confidentiality, should strive to be the same as those in the open community."
- 51 M. Gregg Bloche and Jonathan H. Marks, "Doctors and Interrogators at Guantanamo Bay," *New England Journal of Medicine* 353 (2005): 6-8.
- 52 Physicians for Human Rights and University of Cape Town Health Sciences Centre, *Dual Loyalty and Human Rights in Health Professional Practice* (March 2003) [see note 41]; Office of the United Nations High Commissioner For Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)* (New York and Geneva: United Nations, 2004), <http://www.unhcr.org/refworld/docid/4638aca62.html>.
- 53 The language is from New York State Assembly, Bill No. A6665C-2009 (11 March 2009), <http://open.nysenate.gov/legislation/bill/A6665c-2009>.
- 54 According to the Federation of State Medical Boards' 1995-1996 Exchange, sec. 3 (a comprehensive presentation of information regarding medical boards' structure and disciplinary functions), 46 boards have mandatory reporting requirements for all licensees.
- 55 See Bovbjerg 2006, 20 [see note 14].
- 56 Ibid.
- 57 For example, insufficient investigation of complaints by boards appears to be an endemic problem. See Bovbjerg 2006, 26: Outside audits of medical boards in California and Virginia found "shortcomings in [the] extent of [the] investigation before closure."
- 58 Indeed, to the Task Force's knowledge, to date, only one board has assumed jurisdiction. See *Cox v. Mitchell TX Complaint* (2010), in which the board implicitly assumed jurisdiction when it investigated the complaint against Dr. James Mitchell and held informal proceedings.

59 See *Sarem v. Edmondson* CA Complaint (2005); *Nicholl v. Edmondson* CA Complaint (2007); *Bond v. Leso* NY Complaint (2007). These are discussed in detail in appendix 4.

60 See *Reisner v. Leso* NY Complaint (2010).

61 See chapter 2.

62 See U.S. Department of Defense, Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)" (17 February 2011), requiring that military health professionals have a valid license to practice, and U.S. Department of Defense, DoD 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation* (2004), finding a license valid only if "the issuing authority accepts, investigates, and acts upon quality assurance information, such as practitioner's professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency."

Some states ---exempt the health professionals they employ from state licensure requirements, but Congress has not elected to take that stance with respect to military health professionals. As a result, states should clarify that professionals who are granted licenses from the board remain under that board's jurisdiction. See State of Texas, Office of the Attorney General, Opinion No. JM-1247 (14 November 1990): "A person who is certified or licensed under article 4512c is subject to the provisions of that act, even if that person holds employment that would exempt him or her from the licensing and certification requirements of the act." To interpret otherwise would strip the licensure process of meaning for these professionals. See State of Texas, Office of the Attorney General, Opinion No. JC-0321 (5 January 2001), interpreting Texas statutes to exempt state psychology board licensees who are government employees from board investigations for misconduct. Although this issue has been disputed in Texas, it did not prevent the Texas State Board of Examiners of Psychologists from assuming jurisdiction to investigate and hold informal proceedings on a complaint against former CIA contractor James Mitchell. Danny Robbins, "Texas board won't discipline CIA psychologist," *Associated Press* (25 February 2011).

63 A similar mandatory duty is imposed on California law enforcement officials to investigate reports of child abuse. See *California Penal Code* 11166 and *Alejo v. City of Alhambra*, 75 Cal. App. 4th 1180, holding that the mandatory duty to investigate was reasonable and did not constitute an undue burden on law enforcement because police officers are uniquely placed and specially trained to respond to such complaints, and that failure to report would thwart the scheme of child abuse prevention.

64 Bovbjerg (2006), vi [see note 14].

65 See, e.g., *Reisner v. Catone*, No. 0115400 (N.Y. County State Supreme Court, Civil Branch 2011); Memorandum Contra of Petitioners to Respondent's Motion to Dismiss Filed May 18, 2011, *Bond v. Ohio State Board of Psychology*, Case No. 11 CV 00471 (Court of Common Pleas, Franklin County Ohio 2011); Brief of Appellant Dr. Trudy Bond in support of her appeal from a decision of the East Baton Rouge District Court, *Bond v. Louisiana State Board of Examiners of Psychologists*, 2009-CA-1735 (Louisiana Court of Appeals, First Cir. 2009).

66 See appendix 4 regarding the Ohio State Board of Psychology's responses to *Bond v. James* OH Complaint (2008) and *Reese v. James* OH Complaint (2010). Some responses suggest that the boards might not have investigated at all. See discussions in appendix 4 regarding *Bond v. James* LA Complaint (2007); *Bond v. Zierhoffer* AL Complaint (2008); *Bond v. Leso* NY Complaint (2007); *Reisner v. Leso* NY Complaint (2010); *Sarim v. Edmondson* CA Complaint (2005); *Nicholl v. Edmondson* CA Complaint (2007).

67 See, e.g., Memorandum Contra of Petitioners to Respondent's Motion to Dismiss Filed May 18, 2011 at 7, 20-23, *Bond v. Ohio State Board of Psychology*, Case No. 11 Cv 00471 (Court of Common Pleas, Franklin County Ohio 2011).

68 A statement of reasons in some circumstances could conserve resources reducing the litigation costs of defending lawsuits aimed at compelling boards to disclose their reasons for dismissal. See, e.g., Memorandum Contra of Petitioners to Respondent's Motion to Dismiss Filed May 18, 2011, *Bond v. Ohio State Board of Psychology*, Case No. 11 Cv 00471 (Court of Common Pleas, Franklin County Ohio 2011).

69 See Bovbjerg 2006, 50; see also *Ohio Admin. Code* § 4731-13-36 ("informal disposition may be made of any contested case by stipulation, agreed settlement, consent order, default, or dismissal").

70 For example, the Ohio Administrative Code states that a health professional may satisfy disciplinary requirements through "satisfactory completion of all terms, conditions or limitations" imposed on her "through a board-approved consent agreement or board order." *Ohio Admin. Code* § 4731-13-36. See generally Bovbjerg 2006. Texas Medical Board, *Texas Medical Board Enforcement Process*, <http://www.tmb.state.tx.us/consumers/DisciplinaryProcess.php>, provides for separate closed-door conferences with the parties in which each is afforded the opportunity to present evidence and witnesses but not in the presence of the other party.

71 See *Sarim v. Medical Board of California*, Case No. GIC 855 388 (Superior Ct of California, San Diego 2006); *Bond v. La. St. Bd. of Examiners of Psychologists*, No. 569127 (19th Judicial District Ct., East Baton Rouge Parish, La 2009); *Reisner v. Catone*, No. 0115400 (N.Y. County State Supreme Court, Civil Branch 2011); Verified Complaint for Writ of Mandamus at 8, *Bond v. Ohio State Board of Psychology*, (Court of Common Pleas, Franklin County Ohio 2011).

72 *Bond v. La. St. Bd. of Examiners of Psychologists*, 2009-CA-1735 (La. App. 1 Cir. 6/11/10); *Reisner v. Catone*, No. 0115400 (N.Y. County State Supreme Court, Civil Branch 2011).

73 Brief for Psychologists for Social Responsibility, Psychologists for an Ethical APA, Psychoanalysis for Social Responsibility, The Juvenile Justice Project of Louisiana, and The Institute of Women and Ethnic Studies as Amici Curiae Supporting Plaintiff-Appellant, *Bond v. Louisiana State Board of Examiners of Psychologists*, No. 569127 (19th Judicial District Ct., East Baton Rouge Parish, La 2009). See also, e.g., James Gill, "Tortured Logic," *New Orleans Times-Picayune* (19 May 2010), http://www.nola.com/opinions/index.ssf/2010/05/tortured_logic_james_gill.html.

74 Letter from Jaime T. Monie, Executive Director, La. St. Bd. of Examiners of Psychologists, to Dr. Trudy Bond, Complainant (15 April 2008) [on file with recipient]. Complainants disputed the board's conclusion and sought judicial review of the board's decision. Review was denied on standing grounds. *Bond v. La. St. Bd. of Examiners of Psychologists*, 2009-CA-1735 (La. App. 1 Cir. 6/11/10).

75 See Noralyn O. Harlow, Annotation, Applicability of Statute of Limitations or Doctrine of Laches to Proceeding to Revoke or Suspend License to Practice Medicine, 51 A.L.R. 4th 1147, 1151 (1987).

76 See, e.g., Ohio R.C. Sec. 4732; Min. Stat. Sec. 148.

77 See, e.g., Cal. Bus. & Prof. Code § 2230.5.

78 Noralyn O. Harlow, Annotation, Applicability of Statute of Limitations or Doctrine of Laches to Proceeding to Revoke or Suspend License to Practice Medicine, 51 A.L.R. 4th 1147, 1151 (1987).

- 79 Federal criminal offenses, crimes punishable by death, certain crimes of terrorism, and certain sex offenses carry no statutory time bars. Every state has felonies for which there are no statutes of limitations, often including the most serious instances of homicide and sex offenses. See Charles Doyle, CRS Report for Congress, *Statutes of Limitations in Federal Criminal Cases: An Overview* (updated 9 April 2007). Similar reasoning supports the lack of any statutes of limitations in international criminal law for war crimes, crimes against humanity, and torture. See, e.g., UN Convention Against Torture Art. X; ICC Rome Statute Art. 29; Convention on the Non-Applicability of Statutory Limitations to War Crimes and Crimes Against Humanity.
- 80 See, e.g., Behavioral Science Consultation Team, Joint Intelligence Group, Joint Task Force - Guantanamo, Standard Operating Procedures (2005), para. 9(3), <http://www.aclu.org/files/projects/foiasearch/pdf/D0DDON000760.pdf>: "Sanitize uniforms by placing tape over the name when working in or visiting areas where contact with detainees is possible, including detainee blocks, interrogation buildings, and medical facilities."
- 81 A health professional may have a defense (the defense of laches) if there was an unreasonable delay in bringing disciplinary proceedings and this prejudiced the physician's ability to meet the case against him. See Noralyn O. Harlow, Annotation, Applicability of Statute of Limitations or Doctrine of Laches to Proceeding to Revoke or Suspend License to Practice Medicine, 51 A.L.R. 4th 1147, 1151 (1987). An example of this might be when, as a result of the passage of time, a key witness the health professional wishes to call is no longer available. However, such a defense would be unlikely to succeed if the reason for the delay was the concealment of the health professional's complicity in the abuse, particularly if the health professional played a role in the concealment of his own complicity.
- 82 See Danny Robbins, "Texas board won't discipline CIA psychologist," *Associated Press* (25 February 2011).
- 83 See, e.g., Ohio State Medical Association, "Investigations by the State Medical Board of Ohio - Answers to Frequently Asked Questions," accessed July 2013, <http://www.osma.org/files/documents/tools-and-resources/medical-board-licensing-and-discipline/med-bd-investigation-brochure.pdf>: "ORC§4731.22 (F) authorizes the board to investigate violations of the Medical Practice Act and to take depositions, issue subpoenas and compel the attendance of witnesses and production of documents related to medical board investigations."
- 84 Federation of State Medical Boards, *The Essentials of a Modern Medical and Osteopathic Practice Act* (Euless, TX: Federation of State Medical Boards, 2010), 18.
- 85 Such a book would also be useful to judges reviewing state board actions in response to complaints about such misconduct, as well as to state legislators, attorneys, and others considering reform.
- 86 See, e.g., Tijani R. Cole, "The Courts & The Media Bench Book," *New England Law Review* 35 (2001), 853 (a guide for courts on how to deal with the press within First Amendment constraints); Stephanie P. Brown, National Center for Healthy Housing, *Federal Lead-Based Paint Enforcement Bench Book* (January 2009) (a bench book to promote judicial enforcement of lead-based paint and environmental laws); Pennsylvania Coalition Against Rape, *Pennsylvania Sexual Violence Bench Book* (2007).
- 87 Bovbjerg 2006, 9-10 [see note 15]. See also Richard P. Kusserow, U.S. Department of Health and Human Services, "State Medical Boards and Medical Discipline" (Pub. No. OEI-01-89-00560) (1990), 7 ("Significant staff shortages continue to impede the [medical] boards' disciplinary efforts."); U.S. Department of Health and Human Services, "Medical Licensure and Discipline: An Overview" (Pub. No. P-OI-86-00064) (1986), 2 (finding that medical boards are in "an extremely vulnerable position," and that they lack the funds to handle the jobs before them).
- 88 Marc T. Law and Zeynep K. Hansen, "Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis," *Journal of Health Politics, Policy & Law* 35 (2010), 69, 86.
- 89 Sawicki 2010, 299; Bovbjerg 2006, 38 (finding that board managers and staff often pursue grounds for discipline based on difficulty of investigation and prosecution); Richard P. Kusserow, U.S. Department of Health and Human Services, "State Medical Boards and Medical Discipline" (Pub. No. OEI-01-89-00560) (1990), 10, 15 (noting that because quality of care inquiries tend to be time-consuming, boards tend to look for another basis to take action); U.S. Department of Health and Human Services, "Medical Licensure and Discipline: An Overview" (Pub. No. P-OI-86-00064) (1986), 14 (stating that cases involving incompetency are more difficult to develop than cases involving conviction for a felony or fraud).
- 90 See, e.g., *Reisner v. Catone*, NY Attorney Motion to Dismiss the Verified Petition (14 January 2011) (arguing that "in the view of the distant location of the events, the passage of time, national security implications and the fact that relevant information was likely unavailable, conducting an investigation here would plainly require a major investment of the [New York State Education Department's] resources - - regarding actions that did not involve New York State residents"); *Bond v. Zierhoffer* AL Complaint, Letter from Kathy Cawood to Trudy Bond (18 December 2008) (denying jurisdiction over the complaint submitted by Dr. Bond after what Cawood described as "careful consideration and extensive research into the feasibility of the Board's investigation of the issues raised" in that complaint, filed less than a month earlier).
- 91 See, e.g., Sidney M. Wolfe and others, Public Citizen Health Research Group, *Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2007-2009* (2010).
- 92 Sawicki 2010, 300.
- 93 See chapter 2.
- 94 The Task Force is not aware of any referrals to state boards for related conduct.
- 95 This is not to say that boards cannot adjudicate any complaints without the cooperation of these agencies. Some cases may involve enough publicly available information on which to base an investigation and finding. See, e.g., arguments made by complainants in Ohio. Nor does this mean that boards should not use every tool they have to attempt to secure that compliance. Boards should not preemptively conclude that the federal agencies will not cooperate. If boards have unsuccessfully sought cooperation from the DoD or CIA, they have not disclosed information about these attempts to complainants, courts, or the public.
- 96 Environmental Protection Agency, Office of the Inspector General, "Confidentiality, Anonymity, & Whistleblower Protection," accessed July 2013, <http://www.epa.gov/oig/hotline/protection.htm>.
- 97 United States Department of Labor, "Other Workplace Standards: Whistleblower and Retaliation Protections," accessed July 2013, <http://www.dol.gov/compliance/guide/whistle.htm>.

APPENDIX 4

- 1 This list does not purport to be exhaustive. It includes only the complaints of which the Task Force is aware and that are in the public domain.
- 2 Declaration of John S. Edmondson, MD (19 October 2005), ^ 1, filed in *Al Razak v. Bush*.
- 3 *Id.*
- 4 Complaints filed with the Medical Board of California by Sarim et al. against John Edmondson (11 July 2005).
- 5 *Sarim v. Medical Board of California*, Court Transcript (13 January 2006), 4-5 [hereinafter Sarem Court Transcript].
- 6 Sarem Court Transcript.
- 7 *Sarem v. Medical Board of California*, Ruling on Demurrer and Judgment for Dismissal (16 March 2006), 2.
- 8 Complaint filed with the Medical Board of California by Dr. David Nicholl (26 January 2006). See also Letter from Susan Cady, Central Complaint Unit, Medical Board of California to Dr. David Nicholl, File No. 20-2005-16809 (5 July 2007).
- 9 Complaint filed with the Medical Board of California by Dr. David Nicholl (26 January 2006).
- 10 Letter from Susan Cady, Central Complaint Unit, Medical Board of California to Dr. David Nicholl, File No. 20-2005-16809 (5 July 2007). But see Sarem Court Transcript, 17 (in which Deputy Attorney Kerry Weisel, 18 months earlier, acknowledges the medical board's jurisdiction of the 2005 complaints alleging misconduct that took place on a federal facility and military base).
- 11 See Sarem Court Transcript.
- 12 E-mail from Dr. David Nicholl to Deborah Popowski (17 October 2012).
- 13 *Id.*
- 14 Letter from Jim H. McNatt, MD, Medical Director, Georgia Composite State Board of Medical Examiners, to Dr. David Nicholl (26 June 2007).
- 15 See Larry C. James, *Fixing Hell: An Army Psychologist Confronts Abu Ghraib* (Grand Central Publishing, 2008), 24-28; U.S. Senate Committee on Armed Services, *Inquiry into the Treatment of Detainees in U.S. Custody*, 110 th Cong., 2d sess. (2008), 38, http://www.armed-services.senate.gov/Publications/Detainee%20Report%20Final_April%2022%202009.pdf.
- 16 Task Force Member Deborah Popowski represented Dr. Bond and other complainants in a 2010 complaint with the Ohio State Psychology Board against Dr. Larry James. See *infra*. She continues to represent Dr. Bond in pending litigation against the Ohio Board. In addition to assuming direct representation of Dr. Bond in the 2010 Ohio complaint and related litigation, Ms. Popowski has at times advised Dr. Bond on an ad hoc basis with regard to the other complaints or legal challenges brought by Dr. Bond in other states.
- 17 Complaint filed with the New York Office of Professional Discipline by Trudy Bond against John Leso (5 April 2007).
- 18 Telephone interview with Dr. Trudy Bond (29 February 2008).
- 19 Dr. Steven Reisner is a member of this Task Force.
- 20 Complaint filed with the New York Office of Professional Discipline by Steven Reisner against John Leso (7 July 2010), <http://cja.org/article.php?list=type&type=441>, at 1.
- 21 *Id.*
- 22 Letter from Louis J. Catone to Kathy Roberts, Esquire, Center for Justice & Accountability (28 July 2010), at 2.
- 23 Letter from Kathy Roberts to Louis J. Catone, Director (26 August 2010), at 1.
- 24 *Reisner v. Catone*, Verified Petition, at 2, 9-10.
- 25 *Reisner v. Catone*, Memorandum of Law in Support of the Respondents' Cross-Motion To Dismiss the verified Petition, at 2, 10 -25.
- 26 *Reisner v. Catone*, Court Transcript, at 1.
- 27 Transcript of Oral Argument (6 April 2011), *Reisner v. Catone*, Supreme Court of the State of New York, County of New York: Civil Term: Part19, Index No. 101154/10, <http://cja.org/article.php?list=type&type=415>, 14-15.
- 28 *Reisner v. Catone*, 929 N.Y.S.2d 403 (N.Y. Sup. 2011).
- 29 Larry C. James, Curriculum vitae, at 2 (obtained from Wright State University in 2010); American Psychological Association, Presidential Task Force on Psychological Ethics and National Security (PENS), 2003 Members' Biographical Statement, <http://www.clarku.edu/peacepsychology/tfpens.html>; Complaint filed with the Ohio State Board of Psychology by Michael Reese, Trudy Bond, Colin Bossen, and Josephine Setzler against Larry James (7 July 2010), 2.
- 30 Larry C. James, Curriculum vitae, at 2 (obtained from Wright State University in 2010).
- 31 Complaint filed with the Louisiana State Board of Examiners of Psychologists by Trudy Bond against Larry James (29 February 2008).
- 32 Letter from Jaime T. Monic to Trudy Bond (15 April 2008), 1.
- 33 Letter from Terry Lodge to Jaime T. Monic (23 April 2008), 1.
- 34 *Bond v. Louisiana State Board of Examiners of Psychologists*, Petition for Judicial Review of Administrative Action and Declaratory Judgment (22 July 2008), 13-14. The LSBEP later claimed that it did not receive this additional submission of information in time to consider it during its second meeting on June 20, 2008. *Bond v. LSBEP*, Answer to Petition for Judicial Review of Administrative Action and Declaratory Judgment (25 August 2008), ^ 13.
- 35 *Bond v. LSBEP*, Answer to Petition for Judicial Review of Administrative Action and Declaratory Judgment (25 August 2008), ^ 13.
- 36 *Bond v. LSBEP*, Petition for Judicial Review of Administrative Action and Declaratory Judgment (22 July 2008), W 30-32, at 10.
- 37 *Bond v. LSBEP*, Answer to Petition for Judicial Review of Administrative Action and Declaratory Judgment (25 August 2008), ^ 29.

- 38 *Bond v. LSBEP*, Peremptory Exemption of No Right of Action (5 May 2009), ^ 2.
- 39 *Bond v. LSBEP*, Court Transcript (13 July 2009).
- 40 *Id.*, at 18.
- 41 *Bond v. LSBEP*, Brief of Appellant Dr. Trudy Bond in Support of Her Appeal from a Decision of the East Baton Rouge District Court (15 October 2009).
- 42 *Bond v. LSBEP*, Psychologists for Social Responsibility Amicus Brief (22 February 2010), at 1.
- 43 *Bond v. LSBEP*, First Circuit Opinion (2009 CA 1735) (11 June 2010).
- 44 Complaint filed with the Ohio State Board of Psychology by Trudy Bond against Larry James (8 July 2008).
- 45 Letter from Carolyn Knauss, Investigator, to Trudy Bond (16 September 2008).
- 46 See note 16 describing Task Force member Deborah Popowski's role as counsel for this matter.
- 47 Larry C. James, *Fixing Hell* (2008).
- 48 Complaint filed with the Ohio State Board of Psychology by Michael Reese, Trudy Bond, Colin Bossen, and Josephine Setzler against Larry James (7 July 2010).
- 49 *Bond et al. v. Ohio State Board of Psychology*, Verified Complaint for Writ of Mandamus (13 April 2011).
- 50 Letter from Carolyn Knauss to Beth Collis (26 January 2011)
- 51 *Bond et al. v. OSBP*, verified Complaint for Writ of Mandamus (13 April 2011).
- 52 *Bond et al. v. OSBP*, Petitioners' Request for Production of Documents (13 April 2011).
- 53 *Bond v. OSBP*, Respondent Ohio State Board of Psychology's Motion to Dismiss Complaint in Mandamus (18 May 2011).
- 54 *Bond v. OSBP*, Memorandum Contra of Petitioners to Respondent's Motion to Dismiss (20 July 2011).
- 55 *Bond v. OSBP*, Order of Reference to Magistrate Skeens (24 October 2011).
- 56 Complaint filed with the Texas State Board of Examiners of Psychologists by Jim Cox against James Mitchell (17 June 2010), 27.
- 57 Letter from Carol E. Goodheart, APA President, to the TSBEP re: Complaint filed by Dr. Jim L. H. Cox regarding Dr. James Elmer Mitchell (30 June 2010).
- 58 Danny Robbins, "Texas Board Won't Discipline CIA Psychologist," *Associated Press* (25 February 2011). See also Tex. Gov't. Code, § 2001.056; Tex. Admin. Code, §§ 469.5(h), 470.8(a)(2), (a)(4).
- 59 E-mail from Joseph Margulies to Deena Gaskin (20 October 2011).
- 60 E-mail from Joseph Margulies to Deborah Popowski (25 September 2012).
- 61 Complaint filed with the Alabama Board of Examiners by Dr. Trudy Bond against Dr. Diane Zierhoffer (21 November 2008).

- 62 Complaint filed with the Alabama Board of Examiners by Dr. Trudy Bond against Dr. Diane Zierhoffer (21 November 2008); Letter from Kathy Cawood to Trudy Bond (18 December 2008).
- 63 Letter from Terry Jonathan Lodge to Kathy Cawood (17 February 2009).
- 64 Letter from Trudy Bond to Kathy Cawood (1 April 2009).