



Doctors and Interrogators:

Medical Ethics, Human Rights,
& the Laws of War

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Some Context: Clinical Caregivers Have Performed Effectively, even Heroically, since 9/11

- Iraq: Doctors, Nurses, & Medics often come under fire: mortars, IEDs, & small arms.
 - Provision of lifesaving care to U.S. soldiers, with historically unprecedented ratio of wounded to KIA (a measure of effectiveness).
 - Provision of care to civilians and enemy combatants, often under difficult conditions.
 - Some willingness to challenge questionable orders. Example: Navy doctors' refusal to force-feed hunger strikers (not reported in press).
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Interrogation & Clinical Role Conflict

- What did clinicians assigned to aid interrogators do?
 - How did these clinicians' roles support post-9/11 interrogation strategies – and what were these strategies?
 - Ethical & Legal Issues Posed by Medical Roles in Interrogation & Related Practices
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Roles of Medical Judgment and Psychological Theory in the Design of Interrogation & Counter-resistance Strategies

- Only a small proportion of military clinicians were assigned to work with interrogators; some questioned the appropriateness of this role.
 - Pre-9/11 Military Intelligence Doctrine: No role for physicians or psychologists in interrogation. Not part of MI interrogation training (Ft. Huachuca).
 - Not something psychiatrists or clinical psychologists are trained to do (though both act as consultants to law enforcement agencies).
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A New Interrogation Doctrine

End of 2002: Maj. Gen Geoffrey Miller takes command – A new vision for Guantanamo:

- “Fusion” of all prison functions to support the “interrogation mission”
 - “Behavioral Science Consultation Teams” (“Biscuits”), staffed by psychiatrists &/or psychologists, to “develop ... integrated interrogation strategies and assess ... interrogation intelligence production”
 - Individualized interrogation plans for high-priority detainees
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From Guantanamo to Abu Ghraib

- End of 2002 & early 2003: Gen. Miller & his team develop & implement this approach at Guantanamo
 - Late summer/early fall 2003: With the insurgency in Iraq worsening & Saddam Hussein still at large, Gen. Miller and his team visit Abu Ghraib to assess MI operations.
 - Miller issues a scathing rebuke
 - With support from senior Pentagon officials, operations at Abu Ghraib are quickly refashioned along Guantanamo lines
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Interrogation Process

In-process - Release



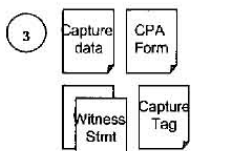
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Detainee arrives from BCT/DIV cage or from obj
- Ideally, we have prior knowledge & info
- Screening team is notified



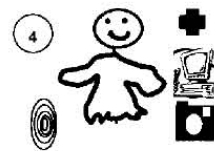
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Detainee is held in temp holding at inprocessing, screeners will assess for loc:
- **Vigilant** - intel value
- **Ganci** - NIV/criminal holding



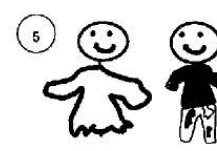
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Screening Team conducts prescreen from docs avail and assesses detainee (s). Places priority for screening



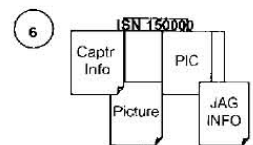
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MP inprocessing - MP database, medical, finger scans, property accounted for, picture



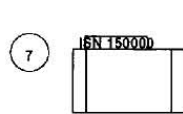
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MI screening is conducted. Screeners determine cooperation and knowledgability, and determine location (gen pap/iso)



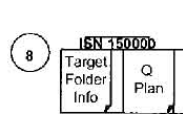
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Ops receives all packets. Ensures capt data is present, assembles target folders, prioritizes intg, passes target folders to intg ncoic



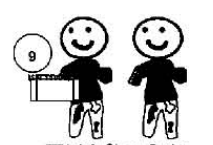
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Intg NCOIC assigns folder(s) to Intg Sections Ldrs (SL), who assign to Tiger Teams (IT)



8

TT receives folder, begins Planning/Prep, 96B's cond research (SIPR/JWICS), questioning plan



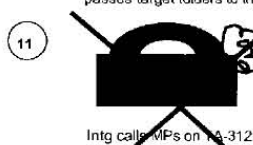
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TT briefs SL on Q-plan, Focus, PIR/HCR/SDR. SL schedules Intg on Booth Schedules



10

SL briefs Ops-OIC on Q-plan, Ops-OIC/NCOIC approves intg Schedules



11

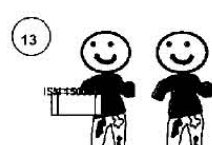
Intg calls MPs on 1A-312 requesting detainee (by ISN) be brought to appropriate booth

Interrogators arrange prisoner transport with SL



12

Interrogation is conducted Intg plus interpreter



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Load intg briefs SL prior to termination, calls MPs to pick up detainee



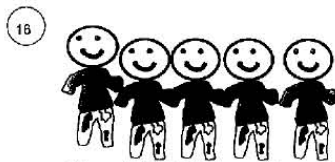
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TT updates DB, writes reports (DIIR, KB, SPOT, IN), submits RFIs to 96B, preps for next interrogation



15

SL QC's all reports and puts them in the que for Chief to QC and send forward



16

SL's and Intg NCOIC plan next day's schedule at approx 1800 hours nightly. Repeat steps 9-16 as often as necessary



17

Detainee is fully exploited & determined to be of no further intelligence value (1-infinity interrogations)



18

Request movement to Ganci - approval granted by C2



19

Remains at Ganci until submitted before Detainee Release Authority



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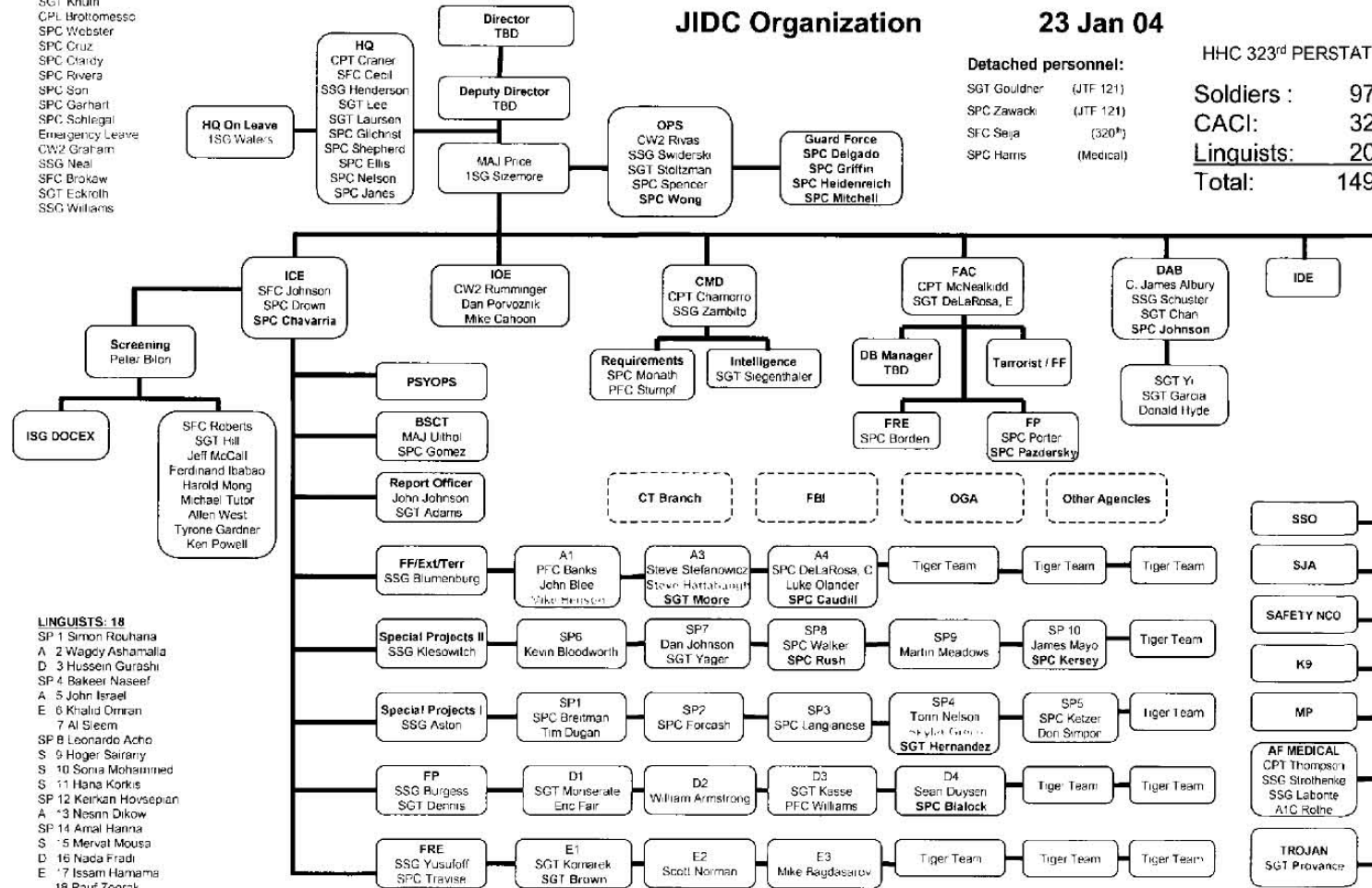
Detainee Release Authority (MI, PMO, JAG) meets to decide continued detention or release

JIDC On Leave:15

SFC Yeske
SGT Knuth
CPL Brotomesso
SPC Webster
SPC Cruz
SPC Clardy
SPC Rivera
SPC Son
SPC Garhart
SPC Schlegel
Emergency Leave
CW2 Graham
SSG Neal
SFC Brokaw
SGT Eskroth
SSG Williams

JIDC Organization

23 Jan 04



Detached personnel:

SGT Gouldner (JTF 121)
SPC Zawacki (JTF 121)
SFC Seja (320*)
SPC Harris (Medical)

HHC 323rd PERSTAT

Soldiers : 97
CACI: 32
Linguists: 20
Total: 149

LINGUISTS: 18

SP 1 Simon Rouhana
A 2 Wagdy Ashamalla
D 3 Hussein Gurashi
SP 4 Bakker Naseef
A 5 John Israel
E 6 Khalid Omran
7 Al Siem
SP 8 Leonardo Acho
S 9 Hoger Sairany
S 10 Sonia Mohammed
S 11 Hana Korkis
SP 12 Kerkan Hovsepian
A 13 Nesrin Dikow
SP 14 Amal Hanna
S 15 Mervat Mousa
D 16 Nada Fradi
E 17 Issam Hamama
18 Rauf Zoerak

On Leave

1. Michael Ar
2. Scott

Tiger Teams: 18 out of 21 teams conducting interrogations

Scheduled to Leave 26 Jan 04

SPC Wong SPC Mitchel SPC Caudill SGT Brown
SPC Delgado SPC Heidenreich SPC Kersey SGT Hernandez
SPC Griffin SPC Pazdersky SPC Johnson SGT Moore
SPC Rush SPC Chavarria SPC Blalock SGT Provanco

SFC Gorman
SPC Schlegal
Emergency Leave
CW2 Graham
SSG Neal
SFC Brokaw
SGT Eckroth
SSG Williams

HQ On Leave
1SG Walters

SGT Lee
SGT Laursen
SPC Glichnst
SPC Shepherd
SPC Ellis
SPC Nelson
SPC Janes

TBD

MAJ Price
1SG Sizemore

ICE
SFC Johnson
SPC Drown
SPC Chavarria

IOE
CW2 Rumminger
Dan Porvoznik
Mike Cahoon

Screening
Peter Bilon

ISG DOCEX

SFC Roberts
SGT Hill
Jeff McCall
Ferdinand Ibabao
Harold Mong
Michael Tutor
Allen West
Tyrone Gardner
Ken Powell

PSYOPS

BSCT
MAJ Uithol
SPC Gomez

Report Officer
John Johnson
SGT Adams

A1

The “Behavioral Science Consultation Team” (“Biscuit”)

- At Guantanamo: Staffed by a psychologist, a psychiatrist, & an aide (Lopez-Martinez Report: psychologists only since mid-2003). At Abu Ghraib: Similar staffing except that psychiatrists continue to serve.
 - “Biscuits” had access to medical information gathered by clinical caregivers.
 - Going Beyond “Rapport-Building” Methods: “SERE” School stressors as counter-resistance techniques.
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Use of “SERE” School Stressors

- Goal of “SERE” School: Train American soldiers at highest risk of capture (pilots, special forces) to resist abusive treatment, rising to the level of torture.
 - Origins of “SERE” Training: Reverse-Engineering of Communist Interrogation Methods. “Brainwashing” of Americans by their North Korean & North Vietnamese captors.
 - Psychological Model, Drawn from Study of (1) Red Army Interrogation Methods, & (2) Animals Exposed to Experimental Stressors: Prolonged, uncontrollable stress induces intense anxiety, making it easier to reshape behavior through systems of reward and punishment.
 - Reward system at Guantanamo: Multiple detainee status levels with different privileges and amenities (specified in detail, down to no. of sheets of toilet tissue per day). “Biscuits” consult on camp organization
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“SERE” Techniques at Guantanamo: Coincidence or Policy?

- “SERE” Stressors at Guantanamo: Prolonged isolation, sleep deprivation, exposure to heat and cold, nudity, “stress positions.”
 - June 2004 Briefing by Gen. James T. Hill (chief of SouthCom): In 2002, a team from Guantanamo visited SERE school in Ft. Bragg & worked with behavioral scientists to develop interrogation techniques for “high-value” detainees. These techniques were submitted to Sec. Rumsfeld for approval.
 - During internal discussions that led to Sec. Rumsfeld’s approval of these methods, their use in SERE training was cited to support their acceptability, according to a senior Pentagon source.
 - FBI ECs we’ve obtained make reference to DoD’s policy of using “SERE” techniques at Guantanamo
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Other Windows onto the Biscuit's Role in Interrogation ...

Testimony by Col. Thomas Pappas (chief of MI at Abu Ghraib) for the Taguba Inquiry:

- MI teams prepared individual “interrogation plans” for detainees, including a “sleep plan” and “medical standards”
 - “A physician and psychiatrist ... are on hand to monitor what we are doing.”
 - “The doctor and the psychiatrist ... look at the files to see what the interrogation plan recommends; they have the final say as to what is implemented.”
 - Psychiatrist also went with interrogators to prison
 - Reviewed all those under a “management plan”
 - Provided “feedback as to whether they were being medically and physically taken care of”
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Other Windows onto the Biscuit's Role in Interrogation ...

From Martinez-Lopez Report & Internal DoD Documents:

- Biscuits gave advice re Detention Facility organization & procedures.
 - Helped to craft interrogation plans.
 - Gave opinions to interrogators re detainees' character & personalities.
 - Gained access to detainees' personal health information and interpreted it for interrogators.
 - Attended interrogations (in person, at first; latter from behind one-way mirrors) & gave feedback to interrogators re technique.
[At Guantanamo, a psychologist attended interrogation of so-called "20th hijacker," according to interrogation logs]
 - Biscuit psychiatrists & psychologists in attendance at interrogations had authority to stop an interrogation at any time.
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Interrogation & Counter-resistance Strategies: Medical Gatekeeping and Oversight

- Aug. 2002 Justice Dept. memo (from Ass't Attorney General Jay Bybee) sought by White House Counsel Alberto Gonzales: Counter-resistance measures aren't torture unless they bring about pain equivalent in intensity to "death, organ failure ... serious impairment of bodily functions," or prolonged & severe mental illness (lasting months or years).
 - Even if these lines are crossed: Not torture if interrogators act "in good faith" by "surveying professional literature" or "consulting with experts"
 - This raises the question of medical gatekeeping.
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Interrogation & Counter-resistance Strategies: Medical Gatekeeping and Oversight (cont.)

- Martinez-Lopez report & Col. Pappas's testimony (Taguba report): Biscuit psychologists & psychiatrists had authority to stop interrogations.
 - Martinez-Lopez report: Other medical personnel were frequently asked to attend interrogations.
 - Debate about the gatekeeping role: Does it help to keep interrogation humane & lawful, or does it invite interrogators to become more aggressive, even abusive, out of the belief that doctors will do the necessary limit-setting?
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What do the Laws of War have to say?

Aggressive interrogation tactics designed to overcome detainee resistance through stress, fear or anxiety are likely to violate international law

- Geneva Convention III protects POWs and imposes obligations in addition to the prohibition on torture:
 - Humane treatment
 - No coercion
 - Protection against violence and intimidation
 - No threats, insults, unpleasant or disadvantageous treatment if POW refuses to answer questions
 - Geneva Convention IV similarly protects civilian detainees and expressly prohibits brutality by civilian as well as military agents
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The Laws of War

- Even unlawful combatants are entitled to basic protections from cruel, humiliating or degrading treatment, and from outrages on personal dignity. (Common Article 3, GCs; Art 75 AP I)
 - If interrogation stressors rise to the level of inhuman treatment or “willfully causing great suffering”, grave breaches of the Geneva Conventions – constituting war crimes – will have been committed
 - Medical personnel who assist with the planning or execution of such interrogation can thus be culpable of war crimes
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A Separate Body of Law: International Human Rights

- Even when the Geneva Conventions do not apply, international human rights law sets limits on aggressive interrogation tactics
 - International Covenant on Civil & Political Rights (1966)
 - prohibits cruel, inhuman, or degrading treatment (as well as torture)
 - requires humane treatment of detainees and respect for their dignity
 - Convention against Torture (1984):
 - in addition to the absolute prohibition of torture, it imposes an obligation on states to review interrogation rules and practices to ensure cruel, inhuman or degrading treatment does not occur
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International Human Rights Law

- The UN General Assembly has also issued statements of principle that appear to proscribe stress techniques used at Guantanamo:
 - These statements prohibit the deprivation—even temporarily—of the use of any of a detainee’s natural senses (such as sight or hearing) or his awareness of place and the passing of time.
 - They also provide: “No detained person while being interrogated shall be subject to violence, threats or methods of interrogation which impair his capacity of decision or his judgment.”

(Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment, UNGAOR 43/173 of 9 Dec. 1988)

International Human Rights Law

- Note: US reservations to international human rights treaties link the definition of cruel, inhuman, or degrading treatment (CID) to conduct prohibited by 5th, 8th and 14th Amendments to the U.S. Constitution
 - A.G. Gonzales took the view (expressed in his confirmation hearings) that the prohibition on CID does not apply to aliens detained outside US (e.g. Bagram & Guantanamo) —a view that sought to create a legal “black hole”
 - McCain Amendment: States that the prohibition applies irrespective of the nationality or geographic location of the detainee (and limits DoD interrogation tactics to those permitted by the Army Field Manual)
 - This difference of opinion has implications for the *ethical* constraints on medical participation in the design and implementation of aggressive interrogation plans. Some of these constraints are contingent on the application of international law.
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International Ethical Norms

WMA Declaration of Tokyo (1975): Addresses complicity in torture:

“The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty...

“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 to 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 are used or threatened.”

International Ethical Norms

WMA Regulations in Time of Armed Conflict
(1983): Much Broader:

2. ... [I]t is deemed unethical for physicians to:
 - A. Give advice or perform ... Diagnostic or therapeutic procedures ... not justifiable in the patient's interest.
 - B. Weaken the physical or mental strength of a human being without therapeutic justification.
 - C. Employ scientific knowledge to imperil health ...
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International Ethical Norms

U.N. Principles of Medical Ethics, Gen. Assembly Res. 37/194 (1982): *Deference to International Law*

Prohibitions based on rules of international law

Principle 2:

- It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.
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International Ethics Norms

Principle 4: Holds that it is a contravention of medical ethics for health personnel, particularly physicians:

(a) 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;

(b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

International Ethical Norms and Guidance

UN Principles of Medical Ethics (cont.) – Principle 3:

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.

- Seems more sweeping in its reach than Principles 2 & 4
 - BUT Principle 3 allows for “professional relationships” for the purpose of *evaluation*
 - Does, or should, this permit a psychiatrist or other health professional to put his/her skills to use on behalf of the interrogation mission, subject only to international law’s constraints?
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Three Ethical “Stories” about Medical Role Conflict

- Hippocratic ideal of undivided loyalty – “Into each house I enter, I shall enter only for the good of my patients ...” *Implication:* Just say no – stay out of the business of interrogation
 - Medical ethics don’t apply – The physician “attached” to MI to assist in interrogation isn’t acting as a physician & isn’t bound by medical ethics norms *Implication:* Not unethical to employ clinical skills to support interrogation
 - The bioethics “mantra” – autonomy, beneficence, nonmaleficence, justice
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Hippocratic Ideal: Undivided Loyalty

- Appealing moral clarity
 - At odds with the reality that medicine serves public purposes in pervasive fashion, often at the expense of individuals. Examples: forensic psychiatry; eligibility for employment, insurance, & other benefits; public health (e.g. vaccination to achieve herd immunity); cost-conscious therapeutic decisions.
 - Underscores need to draw lines between acceptable and unacceptable social purposes
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Medical ethics don't apply – the physician isn't acting as a physician

- Position of the Pentagon's civilian leadership
 - Also urged by some forensic psychiatrists & occupational health physicians [*Analogues: Clinical evaluation bearing on competence for execution; medication that makes inmates competent for execution?*]
 - At odds with the reality that it's *medical* knowledge and skill that is being applied – the doctor is being called upon *because* he/she is a physician
 - Bootstraps on the cultural authority & humanitarian ethos of medicine – the physician in the interrogation room is perceived as a counterweight to impulses toward brutal treatment *because* of medicine's humanitarian ethos
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The Bioethics “Mantra” -- Autonomy, Beneficence, Non-maleficence, Justice

- “Autonomy” is of little help: (1) Military detention isn’t a situation that most view as consistent with exercise of autonomy; (2) Interrogation is not something most detainees would “choose”
 - Obligations of “beneficence” and “non-maleficence” to *individual* patients or clinical subjects don’t address dilemmas created by claims of *social* benefit
 - “Justice” – no guidance – begs the larger question of whether the interrogation & counter-resistance practices at issue are socially desirable
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“Take-Home” Challenge: Toward an Ethics of Clinical Role Conflict

- *Loyalty as Core Precept*: Primacy of medicine’s therapeutic & caring role
 - Acknowledge legitimacy of medicine’s social purposes
 - Mediate between medicine’s caring and public purposes; strong bias toward the former
 - *At a Minimum*: Proscribe use of medical skill and judgment to support activities barred by international law.
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“Take-Home” Precepts: Implications of International Norms

- Some international legal barriers are crossed even by practices that do not pose threats to the physical or mental health of detainees. Geneva Conventions are illustrative.
 - Medical personnel who design, monitor or participate in interrogations violate international law when interrogation practices breach the Geneva Conventions (keep in mind that the GCs prohibit *coercive, threatening, insulting, & disadvantageous treatment* of detainees, not only torture and cruel or inhuman treatment).
 - Medical personnel may be culpable for war crimes if interrogation or counter-resistance activities qualify as torture or inhuman treatment or if those activities willfully cause great suffering.
 - Under the generally accepted interpretation—which rejects the Bush Administration’s position that the prohibition on CID doesn’t apply to Bagram & Guantanamo—such medical personnel are also in contravention of their professional duties as articulated in the UN Principles of Medical Ethics.
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