The Role of Medical Professionals in Detention and Interrogation Operations

More than a year after Camp Delta at Guantánamo opened, officials enthusiastically presented to the public a simple narrative about the interaction of medical personnel and the detainees held there. Officials said that the medical personnel were providing the detainees with an especially high level of medical care. The modern clinic inside the barbed wire enclosure was proudly exhibited to visiting journalists and members of Congress.

The detainees were getting medical treatment far superior to any they had ever received or could hope to receive in their home countries like Afghanistan or Yemen. Officials said that many detainees were scrawny when they arrived but were now gaining weight — metrics were shown to visitors — and their health was attended to with what the superintendent of the hospital described in 2003 as care equivalent to that which the U.S. provides for its own soldiers. "They never had it so good," said Captain Albert Shimkus, the detention center's chief medical officer at the time.[1]

Military doctors performed minor surgery on some prisoners; others were prescribed heart medicines, or statins to control cholesterol. The message was that, yes, these people were in prison but there was a silver lining for them in their doleful situation: they were getting benefits they never would have received but for their imprisonment at Guantánamo — first-rate medical attention and a planned nutrition regimen.

But there was an entirely different universe of professional medical involvement in the detainees' lives that was hidden from wider view: the use of psychologists, psychiatrists and other physicians, and other medical and mental health personnel, to help assist and guide interrogations that were often brutal.

The involvement of medical personnel was ostensibly to make the process more efficient (psychologists could provide guidance to interrogators as to how best obtain information) and safe (medical personnel could monitor the conditions of subjects and, theoretically, intervene if necessary to prevent excessive harm or death). But the other major advantage in enlisting doctors to the interrogation program was that they appeared to provide a sort of ethical approbation for what would occur. The participation of doctors — professional healers — would certify that the activities were not inhumane.

The Office of Legal Counsel relied very heavily on this role of medical personnel to support its much-criticized findings that "enhanced" techniques did not amount to torture or cruel, inhuman or degrading treatment.

It was perhaps for those very reasons — utilizing medical participation to signify humaneness and approval

— that once the participation of doctors in the interrogation program became known publicly, controversies erupted in the professional associations that regard themselves as guardians of the identities and collective ethics of their members.

The New York Times reported on November 30, 2004, that psychiatrists and psychologists were important and direct participants in the interrogation regime at Guantánamo. The article put into public consciousness for the first time the term "biscuits," a nickname for Behavioral Science Consultation Teams (BSCTs). These biscuit teams included behavioral psychologists, who provided guidance for interrogators as to how to best obtain information from detainees. The psychologists did not, as a rule, interact directly with the subjects of interrogations, but observed what was happening, usually through one-way glass and made recommendations to the interrogators. Sometimes, the newspaper reported, the psychologists made their recommendations based on information found in detainees' medical files.

After the article's publication, the professional associations for psychiatrists and psychologists were faced with urgent questions about the proper and ethical role of their members in such situations. The American Psychiatric Association, a medical association consisting of physicians who are specialists in mental health, quickly achieved a consensus. That group decided, with little dissent, that its members could not ethically participate in any way in the interrogations. It was a different situation for the community of psychologists, many of whom considered themselves behavioral scientists and thought it thoroughly appropriate to provide their expert guidance to legitimate authorities, like police and the military. Those psychologists argued that they were not treating the detainees and thus did not owe any professional duty to them; they said their clients were, in fact, the authorities who sought their help. The controversy produced significant battles within the psychologists' group and many questions remain unresolved.

The use of medical personnel in questionable activities also exposed another vexing issue, that of dual loyalties for medical personnel in the military. Military doctors are obligated to abide by the codes of their profession while also simultaneously required as soldiers to obey their commanders.

Medical professionals — specifically, psychologists — had an even more central role in the CIA's interrogation program. Two CIA contract psychologists convinced senior policymakers of the appropriateness of using a military program previously used to train U.S. soldiers during the Cold War to resist interrogation as a model for a regime to break down detainees taken in the new war. The selection of the Survival, Evasion, Resistance and Escape program would come to be recognized as a singularly misguided approach.

Like attorneys, medical personnel were crucial to official authorization for brutal interrogation techniques by the CIA. Unlike lawyers, they were sometimes physically present while the techniques were administered, and in a few cases may have taken part directly.

[In examining the role of health care professionals in detainee treatment, it is important to clarify some definitions at the outset. This chapter uses the terms "clinicians," "doctors," and "medical personnel" broadly, to include not only physicians (including psychiatrists, i.e., medical doctors who specialize in providing mental health treatment) but also psychologists (mental health clinicians who have Ph.D.s, not M.D.s, and are not licensed as physicians), physicians' assistants, nurses and all other medical and mental health professionals.]

Doctors' and Psychologists' Role in Treatment of Prisoners in CIA Custody

Learned Helplessness

Many of the techniques used against Al Qaeda suspects in CIA custody originated in the military's "Survival, Evasion, Resistance and Escape" (SERE) program, a training program designed to enable U.S. Armed Services personnel to endure abusive treatment and evade revealing truthful information while in enemy hands. The methods applied during SERE training, inspired by practices used by communist enemies of the U.S. during the Cold War, include physical slaps, prolonged hooding, stress positions, close confinement in small spaces, slamming into walls, forced nudity, extended isolation, sleep deprivation and waterboarding. According to former chief U.S. Navy SERE trainer Malcolm Nance, the SERE techniques are "dramatic and highly kinetic coercive interrogation methods" patterned after techniques employed by "brutal authoritarian enemies," such as "the Nazis, the Japanese, North Korea, Iraq, the Soviet Union, the Khmer Rouge and the North Vietnamese." [2] Lieutenant Colonel Daniel Baumgartner, former chief of staff for the agency that administers SERE training, has testified that "I'm not going to torture students," but affirmed that "[w]e are simulating an enemy that is not complying with the Geneva Conventions." [3]

SERE training is carefully regulated, both for students' safety, and to ensure that the training increases rather than decreases their confidence in their ability to resist. Dr. Jerald Ogrisseg, former SERE psychologist for the U.S. Air Force Survival School, explained in congressional testimony in 2008 that SERE's purpose was to "enhance student decision-making, resistance, confidence, resiliency, and stress inoculation, and not to break the will of the students and teach them helplessness." An instruction manual for SERE trainers similarly states that "maximum effort will be made to ensure that the students do not develop a sense of 'learned helplessness,' " because "learned helplessness … will render the student less prepared for captivity than prior to the training." [4]

"Learned helplessness" is a phenomenon first described by psychologist Dr. Martin Seligman, based on experiments he performed on animals in the 1960s. Seligman found that when dogs were given electric shocks while confined in harnesses that they could not escape, most later failed to escape shocks when the harnesses were removed.[5] Similar behaviors occur in other animals. For example, one study found that rats placed in a water tank with no exit would attempt to swim for 60 hours before succumbing to exhaustion and drowning. If rats were squeezed in a researcher's hand until they stopped struggling before being placed in the tank, however, they drowned after an average of 30 minutes.[6] Such experiments could not be ethically repeated on human subjects, but Seligman believed that clinical depression was linked to learned helplessness.[7]

Two psychologists with the SERE program, James Mitchell and Bruce Jessen, were heavily influenced by Seligman's findings about "learned helplessness." Mitchell retired from the Air Force SERE school in May 2001, and began working as a consultant.[8] In December 2001, the CIA asked him to review the "Manchester Manual," an Al Qaeda manual seized in the United Kingdom that advised terrorists on resistance to interrogation.[9] Also in December 2001, a small group of psychologists that included Mitchell and a CIA operational psychologist named Kirk Hubbard met with Martin Seligman at Seligman's home in suburban Philadelphia. Hubbard

had some role in the CIA's decision to hire Mitchell and Jessen; in his words, "I didn't make the decision to hire [Mitchell and Jessen]. … I just introduced them as potential assets" to the agency.[10]

Seligman has told reporters that the meeting at his house with Mitchell and Hubbard "did not touch on interrogation or torture or captured prisoners or possible coercive techniques — even remotely," and that he was "grieved and horrified" that his research may have been used to inflict harm. But Seligman did remember that Mitchell had complimented his work on "learned helplessness." [11]

In the months that followed, Mitchell and Jessen drafted a proposal to use SERE techniques against captured members of Al Qaeda.[12] The purpose, though, was the opposite of that of the SERE program: to induce, rather than inoculate against, learned helplessness in order to force detainees into a state of compliance.

In an interview with Task Force staff, Steven Kleinman, a retired Air Force colonel and former interrogator who knew Mitchell professionally before September 11, said that Mitchell's paradigm for interrogation was heavily based on "Martin Seligman's concept of learned helplessness." [13] Mitchell and Jessen, through their counsel, both declined interview requests from Task Force staff. In the past, Mitchell has disputed that learned helplessness research was the basis for the CIA "enhanced interrogation program," [14] but the CIA's own documents suggest otherwise.

A December 2004 description of the program the CIA sent to the Office of Legal Counsel (OLC) explained that "[t]he goal of interrogation is to create a sense of learned helplessness and dependence conducive to the collection of intelligence in a predictable, reliable, and sustainable manner." In order to create this sense of helplessness, "it is important to demonstrate to the [detainee] that he has no control over basic human needs." [15]

CIA officials have confirmed to the press that the techniques were designed to induce learned helplessness. According to former CIA counsel John Rizzo, "the techniques themselves were not intended [or] designed to make [detainees] talk while actually being subjected to those techniques. … I'm a lawyer, not a psychologist, but as I also understand, there's a theory called learned helplessness." [16] Similarly, Jose Rodriguez, head of the CIA's counterterrorism center from 2002 to 2005, has said, "this program was not about hurting anybody. This program was about instilling a sense of hopelessness and despair on the terrorist," and hopelessness led detainees to "compliance." [17]

But according to the Istanbul Protocol, the United Nations' guide for doctors and lawyers documenting and investigating allegations of prisoner mistreatment, reducing detainees to a state of helplessness and despair is itself one of the central harms of torture:

> One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional, and behavioral functions.[18]

The Interrogation of Abu Zubaydah

On March 28, 2002, Abu Zubaydah was captured in a gunfight in Faisalabad, Pakistan. He was believed at the time to be the highest level Al Qaeda suspect in U.S. custody. He was transported to a secret CIA site, most likely in Thailand. There, FBI interrogators Ali Soufan and Stephen

Gaudin began interviewing Abu Zubaydah while doctors worked to stabilize his condition. Soon after, according to Soufan, a CIA team including contractor James Mitchell began directing the interrogation, and using "enhanced" techniques such as nudity and sleep deprivation. When Soufan argued that his questioning had gained valuable intelligence and expressed skepticism about the new techniques, Mitchell reportedly replied, "This is science." [19]

Soufan has written that when the "enhanced" techniques failed to yield the desired results, Mitchell began using longer periods of sleep deprivation. At that point, Soufan said, although Mitchell was operating with headquarters' approval, a CIA operational psychologist left the interrogation for fear of losing his license. Reporters have identified that psychologist as R. Scott Shumate.[20]

Not long after that, Soufan saw a "confinement box" that "looked like a coffin," in which Mitchell was seeking authorization to place Abu Zubaydah.[21] Soufan concluded that "the interrogation was stepping over the line from borderline torture. Way over the line." Soufan left the interrogation, with the approval of his FBI superiors, Assistant Director Pat D'Amuro and FBI Director Robert Mueller.[22]

CIA officials, particularly former Counterterrorism Center Director Jose Rodriguez, have disputed Soufan's account. Most of the disputes concern whether the FBI agents using traditional interrogation techniques or CIA interrogators using "enhanced" methods had more success in obtaining intelligence from Abu Zubaydah — an issue discussed elsewhere. Rodriguez also asserted that Soufan[23] overestimated the contract psychologist's role, and "seemed to blame our contractor for everything," even threatening the contractor with violence at one point. Rodriguez wrote that "[a]t the time the contractor was just an advisor. He was not in charge of the interrogation." Rodriguez, however, does not dispute that the contract psychologist was advising FBI agents as well as CIA interrogators from the beginning, and Soufan does not dispute that Mitchell had CIA headquarters' authorization for his actions.[24]

According to Rodriguez, after Soufan and the FBI left, he met with the contract psychologist and CIA personnel involved in the interrogation and asked the psychologist how long it would take for more aggressive techniques to be effective:

> "Thirty days" was his estimate. I thought about it overnight and the next morning asked the contractor if he would be willing to take charge of creating and implementing such a program. He said he would be willing to take the assignment but could not do it himself. … I agreed that the contractor should bring in someone from the outside to help him work with Agency officers in crafting a program we hoped would save lives.[25]

The program had approval from the highest levels of the U.S. government, as former President George W. Bush wrote in his memoirs:

> CIA experts drew up a list of interrogation techniques that differed from those Zubaydah had successfully resisted. George [Tenet] assured me all interrogations would be performed by experienced intelligence professionals who had undergone extensive training. Medical personnel would be on-site to guarantee that the detainee was not physically or mentally harmed.

> At my direction, Department of Justice and CIA lawyers conducted a careful legal review. They concluded that the enhanced interrogation program complied with the Constitution and all applicable laws, including those that ban torture..[26]

The techniques that President Bush approved and that the OLC deemed legal, in a classified opinion signed by OLC head Jay Bybee (hereinafter "classified Bybee memo"), included not only waterboarding, but: (1) sleep deprivation for up to 11 consecutive days; (2) "cramped confinement" in small, darkened boxes; (3) the placement of an insect inside a confinement box, which the suspect could be told was a stinging insect but was in fact "a harmless insect such as a caterpillar"; (4) "wall standing" and other stress positions; (5) physical assaults including grabbing a suspect's collar, grabbing his face, slapping his face or abdomen, and slamming him into a specially constructed plywood wall.[27]

In approving these techniques, OLC relied heavily on the SERE psychologists' representations. It cited SERE psychologists' assurances that the "enhanced" techniques would not cause prolonged mental harm, stating:

> Through your consultation with various individuals responsible for [SERE] training, you have learned that these techniques have been used as elements in a course of conduct without any reported incident of prolonged mental harm. …
>
> You have informed us that your on-site psychologists, who have extensive experience with the use of the waterboard in Navy training, have not encountered any significant long-term mental health consequences from its use. Your on-site psychologists have also indicated that JPRA [Joint Personnel Recovery Agency] has likewise not reported any long-term mental health consequences of the waterboard.[28]

These "on-site" psychologists were likely James Mitchell and Bruce Jessen, who joined Mitchell at the Abu Zubaydah interrogation in July or August 2002.[29]

OLC also relied on the CIA's representations 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 medical or physical harm" to Abu Zubaydah.[30]

Finally, OLC cited a psychological assessment of Abu Zubaydah that a psychologist sent to John Yoo on July 24, 2002.[31] The assessment states that it is based in part on "direct interviews" with Abu Zubaydah, and is thus widely assumed to have been written by James Mitchell. It states that Abu Zubaydah is "[a]lleged to have written al Qa'ida's manual on resistance techniques," was "[i]nvolved in every major Al Qa'ida terrorist operation," and was a planner of the September 11 attacks.[32] It also states that he is personally resilient, skilled at resisting interrogation, and has no history or symptoms of mental illness.[33]

Ali Soufan has written that the psychological profile's claims about of Abu Zubaydah's role in September 11, and other Al Qaeda operations, were known at the time to be false:

> To this day, I don't understand how anyone could write such a profile. Not only did we know this to be false before we captured Abu Zubaydah, but it was patently false from information obtained after we captured him. … It

> seems they just put down on paper whatever they could to show that Abu Zubaydah was "twelve feet tall." [34]

"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."

The government has never charged Abu Zubaydah with war crimes, and has stated in Abu Zubaydah's *habeas* case that it "has not contended that [he] had any personal involvement in planning or executing" the 1998 embassy attacks or September 11, nor that he "was a member of al-Qaida or otherwise formally affiliated with al-Qaida." [35] The unclassified portions of the psychological profile also make no mention of a head injury that Abu Zubaydah suffered in 1992, which led to serious memory loss and possible psychological consequences.[36]

The psychologists' assurance about the safety of SERE techniques has also been questioned, including within the CIA. The CIA inspector general (IG) reported in May 7, 2004, that according to the head of the CIA's Office of Medical Services (OMS), "OMS was neither consulted nor involved in the initial analysis" of the interrogation techniques.[37] OMS took issue with the Office of Technical Services and contract psychologists' conclusions about the techniques, particularly waterboarding:

> OMS contends that the expertise of the SERE psychologist/interrogators on the waterboard was probably misrepresented at the time, as the SERE waterboard experience is so different from the subsequent Agency usage as to make it almost irrelevant. Consequently, according to OMS, 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.[38]

In an interview with Task Force staff, former CIA General Counsel John Rizzo said that other agency personnel "swear they consulted with the Office of Medical Services," though he lacked first-hand knowledge of the consultations. Rizzo said that medical personnel, in addition to psychologists, monitored Abu Zubaydah's interrogation:

> [I]n terms of overseeing the program, there were always medical people. I know there were psychologists and physicians' assistants. I believe doctors would go through periodically but I can't say that MD's were there constantly.

Rizzo said that because Abu Zubaydah had been wounded during capture and "was the first one" subjected to the techniques, "people wanted to be extraordinarily careful" and "I believe there were medical doctors from OMS on site." [39]

Dr. Kirk Hubbard wrote in an email to Task Force staff that

> I don't think OMS was involved in the initial analysis of the enhanced interrogation techniques, but … an OMS medical doctor observed at least some of the interrogations of [Abu Zubaydah].[40]

The report of the CIA Office of Inspector General (CIA OIG report) stated that investigators had viewed the videotapes of Abu Zubaydah's waterboarding. In contrast to the OLC's statement that waterboarding "will not be used with substantial repetition," [41] "OIG identified 83 waterboard applications, most of which lasted less than 10 seconds." [42] There were other differences as well:

> OIG's review of the videotapes revealed that the waterboard technique employed at [redacted] was different from the technique as described in the DoJ opinion and used in the SERE training. The difference was in the manner in which the detainee's breathing was obstructed. At the SERE School and in the DoJ opinion, the subject's airflow is disrupted by the firm application of a damp cloth over the air passages; the interrogator applies a small amount of water to the cloth in a controlled manner. By contrast, the Agency interrogator [redacted] continuously applied large volumes of water to a cloth that covered the detainee's mouth and nose.[43]

In 2008, the Senate Armed Services Committee found that the divergence between SERE school and actual CIA practices on detainees were not restricted to waterboarding, or to any particular technique. SERE schools use "strict controls" to reduce the threat of harm to students, including

> medical and psychological training for students, intervention by trained psychologists during training, and code words to ensure that students can stop the application of a technique at any time should the need arise. Those same controls are not present in real world interrogations. [44]

In 2009, the Department of Justice's (DOJ) Office of Professional Responsibility (OPR) criticized the OLC memo for relying "almost exclusively on the fact that 'the proposed interrogation methods have been used and continue to be used in SERE training' without 'any negative long-term mental health consequences.' " They found this reliance unwarranted "[i]n light of the fact that the express goal of the CIA interrogation program was to induce a state of 'learned helplessness.' " [45]

In addition to their role in developing the program and advocating for the use of coercive techniques, Mitchell and Jessen may have directly participated in interrogations. The CIA OIG report describes the individuals who waterboarded Abu Zubaydah and Abd al-Rahim al-Nashiri as "SERE psychologist/interrogators" or "psychologist/interrogators." The DOJ OPR report similarly states that "psychologist/interrogators administered all of the interrogation sessions involving EITs [enhanced interrogation techniques]" for Abu Zubaydah, and administered the waterboard to al-Nashiri on two occasions.[46] The Associated Press, which cited anonymous U.S. intelligence officials, has also reported that Mitchell and Jessen personally waterboarded Abu Zubaydah and Abd al Rahim al-Nashiri.[47]

This is not to say that Mitchell and Jessen were acting without headquarters' guidance or oversight. Both the OIG report and the DOJ OPR report state that CIA headquarters closely monitored Abu Zubaydah's and al-Nashiri's interrogations, including videotapes of the sessions. Based on the CIA's response to Freedom of Information Act requests, Abu Zubaydah's interrogators included "medical update" and "behavioral comments" in daily cables to CIA headquarters describing the interrogation in August 2002.[48]

Hubbard wrote in an email to Task Force staff that

> Drs. Mitchell and Jessen had no authority to establish policy or procedure, or make independent decisions regarding the interrogation program. The

> conditions of their contract prohibited that. Everything they did was specifically approved by the CIA.[49]

Hubbard also wrote that, contrary to some accounts he had seen in the press, Mitchell and Jessen "were not promoting themselves; the CIA approached them." [50]

The Washington Post has reported that Mitchell and Jessen concluded that Abu Zubaydah was fully "compliant," and there was no need or use for further waterboarding sessions, before CIA headquarters did. According to the *Post's* source, the CIA counterterrorist center sent back cables advocating for waterboarding to continue for another 30 days, and told Mitchell and Jessen that "you've lost your spine." Mitchell and Jessen requested that the officials observe a waterboarding session at the site, after which they agreed that no further waterboarding was needed.[51] It is impossible to confirm the details of this incident without access to classified information, but the *Post's* reporting is consistent with the public portions of the CIA OIG report.[52]

In a possible reference to the same incident, Abu Zubaydah later told the Red Cross that during the period when he was undergoing waterboarding, "I collapsed and lost consciousness on several occasions. Eventually the torture was stopped by the intervention of the doctor." He stated, however, that the intervention came long after he suffered severe physical pain and prolonged mental stress. Abu Zubaydah described waterboarding as causing severe pain, repeated vomiting and hopelessness: "I struggled against the straps, trying to breathe, but it was hopeless. 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." [53]

Abu Zubaydah made further allegations about continued physical and mental harm during his Combatant Status Review Tribunal (CSRT) hearing, though the details were not clear and most of his statements about treatment at the CIA facility were redacted.[54] His medical records, statements about his treatment in custody, and information about his current medical condition are also largely classified.

According to a filing by Abu Zubaydah's counsel in Lithuania, requesting victim status in an inquiry into allegations of CIA prisons, while they cannot reveal "the details of his physical and psychological injuries because all information obtained from Abu Zubaydah is presumed classified under a U.S. court order," publicly available records show that his prior head injuries

> were exacerbated by his ill-treatment and by his extended isolation. As a consequence, he has permanent brain damage and physical impairment. He suffers blinding headaches, and has an excruciating sensitivity to sound. Between 2008 to 2011 alone, he experienced more than 300 seizures. At some point during his captivity, the CIA removed his left eye. His physical pain is compounded by his awareness that his mind is slipping away. He suffers partial amnesia, and has trouble remembering his family.[55]

Elsewhere, Abu Zubaydah's counsel has alleged that he had been prescribed Haldol, a powerful antipsychotic.[56]

Photographs confirm that Abu Zubaydah is missing an eye, but all other medical records or evaluations that would confirm or refute these allegations remain classified.

Refinements to the CIA Program by the Office of Medical Services

On January 28 2003, the CIA issued and George Tenet signed written guidelines regarding interrogation and conditions of confinement for detainees in CIA custody.[57] This was the first agency-wide written guidance on the program.

The Conditions of Confinement Guidelines are largely redacted. One of the few legible passages states that "[d]ue provision must be taken to protect the health and safety of CIA detainees, including basic levels of medical care." [58]

The Interrogation Guidelines categorized isolation, sleep deprivation of 72 hours or less, reduced caloric intake, use of loud music or white noise, and the use of diapers "generally not to exceed 72 hours [redacted]" as "standard" interrogation techniques. "Enhanced techniques" included close confinement, stress positions, wall standing, harmless insects, walling, slapping or grabbing a detainee's face or body, more prolonged periods of diapering and sleep deprivation, waterboarding, and "such other techniques as may be specifically approved" by headquarters.[59]

In order to approve a request for "enhanced" techniques, the director of the counterterrorism center had to certify that "appropriate medical and psychological personnel have concluded that the use of the Enhanced Technique(s) is not expected to produce 'severe physical or mental pain or suffering.' " [60] The guidelines also required that "[a]ppropriate medical and psychological personnel" be available for consultation with or travel to the interrogation site for standard techniques, and physically present at the interrogation site for the application of enhanced techniques. Whether on-site or off-site, medical and psychological personnel were instructed to suspend the interrogation if they found that "significant and prolonged physical or mental injury, pain, or suffering is likely to result if the interrogation is not suspended." If this occurred, the interrogation team would be required to "report the facts to Headquarters for management and legal review to determine whether the interrogation may be resumed."[61]

The CIA's OMS issued its first, draft guidelines on medical treatment of detainees in March 2003. That first draft has not been publicly released, but revised versions issued in September 2003, May 2004, and December 2004 are publicly available in redacted form.[62] There are subtle differences between the three versions.

The guidelines state that CIA captives

> may be subjected to a wide range of legally sanctioned techniques, all of which are also used on U.S. military personnel in SERE training programs. These [techniques] are designed to psychologically "dislocate" the detainee, maximize his feeling of vulnerability and helplessness, and reduce or eliminate his will to resist our efforts to obtain critical intelligence.[63]

The guidelines describe OMS's obligation to detainees as "assessing and monitoring the health of all Agency detainees subject to 'enhanced' interrogation techniques" and "determining that the authorized administration of these techniques would not be expected to cause "serious or permanent harm." A footnote points out that, according to the Department of Justice, mental harm is not considered serious unless it lasts "months or years," and "in the absence of prolonged mental harm, no severe mental pain or suffering would have been inflicted." [64]

"... the longest consecutive period a detainee was deprived of sleep was 180 hours."

The initial version of the OMS guidelines appears not to mention medical professionals' common obligation to "do no harm," rather than ensuring that harm inflicted is not "serious or permanent." [65] Later versions do acknowledge that "[a]ll medical officers remain under the professional obligation to do no harm," but this is immediately followed by several redacted lines of text and a conclusion that "[m]edical officers must remain cognizant at all times of their obligation to prevent 'severe physical or mental pain or suffering.' " [66] — the OLC's standard, not the Hippocratic Oath's.

Throughout, the guidelines repeatedly call for medical professionals to monitor the severity of harm imposed by interrogators on detainees, rather than preventing any harm. For example, the 2003 guidelines state that "[d]etainees can safely be placed in uncomfortably cool environments for varying lengths of time, ranging from hours to days." [67] They provide several paragraphs of instructions (largely redacted) for monitoring temperatures to prevent hypothermia. Later versions include more specific instructions regarding "water dousing" — soaking detainees in cold water.[68]

The guidelines' requirements with regard to stress positions, shackling and sleep deprivation are heavily redacted. The 2003 guidelines say that shackling "in a non-stressful position requires only monitoring for the development of pressure sores with appropriate treatment and adjustment of the shackles as required," and that being shackled upright for up to 72 hours "can be approved if the hands are no higher than head level and weight is borne fully by the lower extremities." [69] The approval for "standard" sleep deprivation is also 72 continuous hours, with or without shackling, but this could apparently be repeated after only a short rest. Clinicians were instructed that examinations of detainees undergoing sleep deprivation "should include the current numbers of hours without sleep; and if only a brief rest preceded this period, the specifics of the previous deprivation also should be required." [70] Later versions of the guidelines restrict "standard" sleep deprivation and shackling to 48 hours.[71]

OMS's representations about the medical safety of the techniques and clinicians' role in monitoring detainees were essential to the OLC's 2005 re-affirmation of the legality of several CIA techniques. Three memos, signed in 2005 by the OLC's acting head, Steven Bradbury, again and again rely on OMS to ensure that detainees are not subjected to severe physical suffering or prolonged mental harm. One of the memos, for example, states with regard to sleep deprivation:

> The primary method of sleep deprivation involves the use of shackling to keep the detainee awake. In this method, the detainee is standing and is handcuffed, and the handcuffs are attached by a length of chain to the ceiling. The detainee's hands are shackled in front of his body, so that the detainee has approximately a two-to-three foot diameter of movement. The detainee's feet are shackled to a bolt in the floor. Due care is taken to ensure that the shackles are neither too loose nor too tight for physical safety. We understand from discussions with OMS that shackling does not result in any significant physical pain for the subject.[72]

Bradbury wrote that detainees were continually monitored by closed-circuit television to ensure that they would not fall asleep and dangle from their shackles, and monitored for edema, swelling in the lower legs:

> OMS has advised us that this condition is not painful, and that the condition disappears quickly once the detainee is permitted to lie down. Medical personnel carefully monitor any detainee being subjected to standing sleep deprivation for edema or other physical and psychological conditions.[73]

Because several detainees did experience edema as a result of standing sleep deprivation, the CIA, in consultation with OMS, developed an alternative protocol for "horizontal sleep deprivation," which involved shackling detainees' arms and legs to the floor far enough away from their bodies that the limbs "cannot be used for balance or comfort" but not so far as to "force the limbs beyond natural extension or create tension on any joint." The CIA assured OLC that this was "not significantly painful, according to the experience and professional judgment of OMS and other personnel." [74]

While they were being shackled in a standing position for purposes of sleep deprivation, detainees were kept in diapers rather than being unshackled or allowed to use a bucket or latrine. The CIA told OLC in 2005 that releasing a detainee from shackles during sleep deprivation to urinate or defecate "would interfere with the effectiveness" of the sleep deprivation technique.[75] The May 2004 OMS guidelines list diapering "generally for periods not greater than 72 hours" as a standard measure, "prolonged diapering" as an enhanced measure, and states that only the medical limitation on diapering is "[e]vidence of loss of skin integrity due to contact with human waste materials." [76] In 2005, however, the CIA assured OLC that diapers were regularly checked and changed if soiled, and detainees had not developed skin lesions.[77]

According to the Bradbury memos, the longest consecutive period a detainee was deprived of sleep was 180 hours.[78]

The OMS guidelines describe waterboarding as "by far the most traumatic of the enhanced interrogation techniques," and the only one requiring the presence of a physician as opposed to a physician's assistant. It discusses serious risks based on the CIA's previous experience administering the waterboard:

> [F]or reasons of physical fatigue or psychological resignation, the subject may simply give up, allowing excessive filling of the airways and loss of consciousness. An unresponsive subject should be righted immediately, and the interrogator should deliver a sub-xyphoid thrust to expel the water. 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.[79]

Before this degree of harm is reached, however, OMS stated that "a series of several relatively rapid waterboard applications is medically acceptable. … Several such sessions per 24 hours have been employed without apparent medical complication." OMS recommended a careful medical assessment before more than 15 waterboard applications within a 24 hour period, and warned of "cumulative" effects after three to five consecutive days of intense waterboarding.[80]

The 2005 OLC memos contain more details about potential medical complications of waterboarding, and precautions taken to avoid them. These included: (1) feeding detainees

liquid diets beforehand to reduce the risk of vomiting, and (2) using saline solution instead of water to reduce the risk of pneumonia. The memo also states that equipment for emergency resuscitation and medical supplies for performing a tracheotomy are available for detainees subjected to waterboarding.[81]

Throughout the 2005 memos, Bradbury placed great reliance on OMS's assurances about the safety of the techniques and their role in monitoring interrogation and modifying techniques as needed. A May 10 memorandum on the legality of individual techniques under the Torture Statute cited a CIA assurance that medical and psychological personnel are continuously present and that "[d]aily physical and psychological evaluations are continued" during the entire period of use for "enhanced" techniques. [82]

OMS's participation was especially crucial to Bradbury's finding that waterboarding and sleep deprivation enforced by shackling did not violate the Torture Statute. Footnote 31 stated that OMS had assured OLC that "although the ability to predict is imperfect — they would object to the initial or continued use of any technique if their psychological assessment of the detainee suggested that the use of the technique might result in post traumatic stress disorder (PTSD), chronic depression, or other conditions that could constitute prolonged mental harm." [83] The memorandum concluded with a paragraph again emphasizing the crucial role of medical and psychological personnel, and OLC's assumption that in addition to monitoring interrogations and stopping or adjusting techniques when needed, "medical and psychological personnel are continually assessing the available literature and ongoing experience with detainees." [84]

A second memo, on whether combined techniques would rise to the level of torture, states of medical professionals' evaluations of detainees and monitoring of interrogations that "these safeguards, which were critically important to our conclusions about individual techniques, are even more significant when techniques are combined." The same memo later states that OMS's role is "essential to our advice" that the CIA program does not violate the Torture Statute.[85] A third memo, regarding whether the CIA program constitutes cruel, inhuman or degrading treatment, places similar reliance on OMS.[86]

It is unclear whether the limits discussed in the OMS guidelines and the 2005 OLC memos were consistently applied in practice.[87] Steven Bradbury, the author of the memoranda, later told DOJ investigators that he had deferred to the CIA's representations regarding the precise implementation and effectiveness of the "enhanced" techniques, because "[i]t's not my role, really, to do a factual investigation." [88] The CIA IG's Office has conducted several reviews on the program since its initial 2004 report, but they are all fully classified.

High-Value Detainee Accounts and Red Cross Findings on the CIA Interrogation Program

In 2006, 14 high-value detainees (HVDs) were transferred from CIA prisons to military custody at Guantánamo Bay, where they met with representatives of the International Committee of the Red Cross (ICRC) for the first time. The ICRC's account of their interviews has been published. The detainees' accounts of their treatment are highly consistent with one another, although they had limited if any ability to coordinate their statements. According to the ICRC, "the consistency of the detailed allegations provided separately by each of the 14 adds particular

weight" to the claims. The detainees' accounts of interrogation techniques and the role of clinicians are broadly, though not entirely, consistent with the officially released documents on the CIA program. But the detainees' characterizations of the level of pain and suffering resulting from their treatment are dramatically different from that of OMS.

Several of the detainees described "doctors" monitoring their condition, and in some cases instructing interrogators "to continue, to adjust, or to stop particular methods." [89] The medical personnel did not identify themselves, and they may well have been physicians' assistants or para-professionals as opposed to licensed physicians.

Khalid Sheikh Mohammed described during waterboarding sessions "a person he assumed to be a doctor" regularly checking a device attached to one of his fingers, which the ICRC concluded was likely a pulse oxymeter. Mohammed alleged "that on several occasions the suffocation method was stopped on the intervention of a health person who was present in the room." [90] It is not clear whether this intervention was by a physician or by another medical person, such as a physician's assistant.

According to the ICRC, waterboarding "caused considerable pain" for all three detainees who experienced it, and resulted in vomiting and incontinence in Abu Zubaydah's case. Mohammed alleged that he suffered injuries to his wrists and ankles as a result of struggling against his restraints during waterboarding.[91]

Regarding shackling in a standing position, the ICRC reported that the technique was used "for periods ranging from two or three days continuously, and for up to two or three months intermittently," always while naked. As a result, many detainees had suffered leg or ankle swelling. While the detainees were frequently checked by U.S. personnel, three alleged that they had fallen asleep in the position and were temporarily suspended from their shoulders, causing painful injuries. Walid bin Attash, who had an artificial leg, alleged that interrogators sometimes removed it to increase the stress and fatigue of being shackled to the ceiling. As a result, his good leg sometimes collapsed and his handcuffs cut into his wrists. Four detainees, including bin Attash, alleged that they had to remain standing in their own excrement because their diapers were not replaced. Four detainees also alleged that they were doused with cold water while shackled in a standing position, and "[s]everal thought this was in order to clean away the feces which had run down their legs when they defecated while held in the prolonged stress standing position." [92]

Bin Attash reported that during a later period of forced standing, his lower leg was measured daily with a tape measure to check for swelling by someone he assumed was a doctor. Eventually, the doctor allowed him to sit, though he remained shackled in a way that was "very painful on my back." Detainee Riduan Isamuddin (aka Hambali) also alleged that a doctor had eventually put an end to a period of forced standing, telling him, "I look after your body only because we need you for information." Laid Saidi, a detainee held in a CIA-run prison in Afghanistan, told *The New York Times* that after his legs had become painfully swollen after an extended period of being shackled in a standing position, a doctor had treated him with an injection.[93]

Nine detainees alleged that they were beaten by interrogators, including being punched and kicked as well as being slapped and having their heads slammed into walls. One detainee alleged being beaten "to the extent that I was bleeding." Abu Zubaydah alleged that he was slammed into a solid wall before being slammed against a wall that had been covered with plywood sheeting to absorb some of the impact.[94]

The ICRC wrote that the ethical obligations of doctors and other health professionals forbade

> ruling on the permissibility, or not, of any form of physical or psychological ill-treatment. The physician, and any other health professionals, are expressly prohibited from using their scientific knowledge and skills to facilitate such practices in any way. … [T]he participation of health personnel in such a process is contrary to international standards of medical ethics.[95]

The ICRC reported after an initial period that ranged from weeks to months, the detainees' treatment became less harsh and conditions began to improve.[96] There were limits to the improvements, though. Even when not undergoing sleep deprivation, detainees alleged that they were continuously kept handcuffed and/or shackled in their cell, for periods of up to 19 months. One detainee stated that his ankle shackles had to be cut off twice because they had rusted shut. Eleven of the detainees also alleged that they were kept naked for extended periods, ranging from weeks to months, often in cells that were excessively cold.[97]

Several detainees alleged during their CSRTs [98] that they suffered continued ill health, mental or physical, as a result of their treatment by the CIA, which they all termed "torture." Abu Zubaydah's allegations are noted above. Abd al-Rahim al-Nashiri stated, "Before I was arrested I used to be able to run about 10 kilometers. Now I cannot walk for more than 10 minutes. My nerves are swollen in my body." [99] Majid Khan stated that at Guantánamo, he has twice "chewed my artery" and been forced to wear an anti-suicide smock as a result.[100]

Again, the medical records that could verify these claims, or provide other evidence of the 14 HVDs' current medical conditions, are classified.[101] With the exception of the ICRC report, which was leaked to the press without authorization, and excerpts from the CSRTs, the HVDs' descriptions of their own treatment are also classified. Except for the CIA OIG report, almost all of the CIA documents that would corroborate or refute these claims are likewise classified.

As a result of the secrecy surrounding the program, the OMS personnel involved in medical and psychological evaluation of detainees and monitoring of interrogations have never been publicly identified or interviewed. It is unclear whether they are medical doctors or physicians' assistants, and whether they were government employees or contractors.[102]

What can be said is that the detainees' accounts in the ICRC report are far more consistent with medical literature on the effects of ill treatment on prisoners than the OMS guidelines are. According to two experts on the subject, Leonard Rubenstein of Physicians for Human Rights and retired Brigadier General Stephen Xenakis, M.D.

> The OMS endorsement that these methods do not cause severe mental or physical pain or suffering is contrary to clinical experience and research. The OMS failed to take account of pertinent medical and nonmedical literature about the severe adverse effects of enhanced methods, including the cumulative effects on prisoners subjected to practices such as sensory deprivation, sleep deprivation, waterboarding, and isolation[103]

The CIA's representations about the medical effects of its program also disregarded an older body of literature about the effects of communist interrogation techniques on American

POWs. For example, a 1957 article by Albert Biderman about methods used to extracting false confessions from U.S. airmen during the Korean War describes "one form of torture experienced by a considerable number of Air Force prisoners of war" as follows:

> The prisoners were required to stand, or sit at attention, for exceedingly long periods of time — in one extreme case, day and night for a week at a time with only brief respites. In a few cases, the standing was aggravated by extreme cold.[104]

Biderman wrote that POWs "who underwent long periods of standing and sitting … report no other experience could be more excruciating." [105]

Communist Control Techniques, a 1956 study on the effects of KGB and communist Chinese detention and interrogation commissioned by the CIA and authored by psychologists Harold Wolff and Lawrence Hinkle, reached similar conclusions about a regime of total isolation, cold temperatures, sleep deprivation and food deprivation:

> The effects of isolation, anxiety, fatigue, lack of sleep, and chronic hunger produce disturbance of mood, attitudes, and behavior in nearly all prisoners. The living organism cannot entirely withstand such assaults. The Communists do not look upon these assaults as "torture." Undoubtedly, they use the methods which they do in order to conform, in a typical legalistic manner to overt Communist principles which demand that "no force or torture be used in extracting information from prisoners." But these methods do, of course, constitute torture and physical coercion. All of them lead to serious disturbances of many bodily processes.[106]

Wolff and Hinkle described the method of

> requiring the prisoner to stand throughout the interrogation session or to maintain some other physical position which becomes painful. This, like other features of the KGB procedure, is a form of physical torture, in spite of the fact that the prisoners and KGB officers alike do not ordinarily perceive it as such. Any fixed position which is maintained over a long time ultimately produces excruciating pain.[107]

Wolff and Hinkle also discussed the risk of swelling and edema, which contrary to OMS guidance they describe as "intensely painful," and state:

> Men have been known to remain standing for periods as long as several days. Ultimately they develop a delirious state, characterized by disorientation, fear, delusions, and visual hallucinations. This psychosis is produced by a combination of circulatory impairment, lack of sleep, and uremia.[108]

As discussed further in Chapter 8, the ICRC report is also consistent with clinical evaluations and other former detainees' reports on the harmful effects of "enhanced" interrogation in CIA or military custody.

The Guantánamo BSCTs

Medical and mental health professionals also had a key role in the use of brutal interrogation techniques by the Department of Defense (DOD), particularly at Guantánamo Bay. At Guantánamo, Behavioral Science Consultant Teams (BSCTs), composed of psychologists, psychiatrists and mental health technicians (who were apparently not psychiatrists or psychologists), had a central role. The BSCTs signed memos requesting authorization to use SERE techniques against Guantánamo detainees, monitored interrogations, and advised interrogators about techniques. They and other members of the interrogation team had access to detainees' medical records, and detainees have repeatedly alleged that their medical care depended on cooperation with interrogators.

The BSCTs, unlike the SERE psychologists affiliated with the CIA program, did not seek to become involved with interrogation. In June 2002, psychiatrist Major Paul Burney, psychologist Major John Leso, and a psychiatric technician, whose name and rank have never been made public, deployed to Guantánamo Bay. Leso and Burney thought their mission would be to treat U.S. servicemembers. Instead, Burney later told the Senate Armed Services Committee, they

> were hijacked and immediately in processed into Joint Task Force 170, the military intelligence command on the island. It turns out we were assigned to the interrogation element. … Nobody really knew what we were supposed to do for the unit.[109]

Burney stated that he and Leso had never received any training on interrogation, nor was there a standard operating procedure in place for the BSCT clinicians when they arrived.[110] There had been another, very different BSCT working at Guantánamo before Leso's and Burney's. It was affiliated with the DOD's Criminal Investigation Task Force, a group of military criminal investigators charged with determining which detainees would be prosecuted. A member of that team, Navy Criminal Investigative Service (NCIS) psychologist Michael Gelles, explained that he and his fellow BSCT members reviewed files, watched interrogations and provided advice about specific detainees, but "[p]sychologists don't go in. … [T]here was no reason for psychologists to be in the room." [111] Gelles said that he had over a decade of experience doing similar consultation for law enforcement interrogations, including the investigation into the USS Cole bombing; "[t]hat's what I did for a living." His colleagues were similarly experienced, and were focused on obtaining information that would be legally admissible in court.[112]

Gelles said Major General Michael Dunlavey, the commander of Guantánamo's interrogation group, wanted his team based at Guantánamo full time. When Gelles told Dunlavey this was not possible, Dunlavey's response, Gelles said, was " 'Fine. Then I'll get my own.' And then he went out and asked the army to give him some psychiatrists and psychologists … and he built a behavioral science team." [113] Gelles said that the new BSCT team lacked appropriate training for the assignment they were given.[114]

Dunlavey has disputed this account. In 2007, he told the Senate Armed Services Committee that he was in the hospital for much of the month of June, and did not know who created the BSCT.[115]

On August 6, 2002, the U.S. Southern Command issued a new confidentiality policy for health care providers at Guantánamo, which stated that communications between detainees and doctors, psychiatrists, psychologists and therapists "are not confidential and are not subject to the assertion of privileges by or on behalf of detainees." Rather, medical and mental health personnel were instructed to "convey any information concerning … a military or national security mission" obtained during treatment of detainees to "non-medical military or other United States personnel with an apparent need to know the information." This exchange of information could occur either at the initiative of medical personnel or interrogators.[116] Gelles confirmed that interrogation personnel had access to medical records both in Afghanistan and Guantánamo in 2002, though the NCIS did not use them for fear that it would render detainees' statements inadmissible in court.[117] Standard operating procedures for the BSCTs from the fall of 2002 indicate that the BSCTs were assigned to act as the liaison between interrogators and medical staff, and "[d]escribe the implications of medical diagnoses and treatment for the interrogation process." [118]

In September 2002, the three BSCT members and four interrogators received training in SERE techniques at Fort Bragg, N.C. According to the trainees, the trainers discussed both physical and psychological pressures used in SERE school that could be used on detainees, including "disrupt[ion of] prisoner sleep cycles," "invasion of personal space by a female," solitary confinement, walling, hitting in a way that avoided injury, the use of military dogs to enhance exploitation, hooding, and exploitation of fears.[119] According to Burney, the instructors stressed

> time and time again that psychological investigations have proven that harsh interrogations do not work. At best it will get you information that a prisoner thinks you want to hear to make the interrogation stop, but that information is strongly likely to be false.[120]

The instructors and the chief psychologist for the Army's Special Operations Command, Lieutenant Colonel Louie "Morgan" Banks, told investigators that they did not remember discussion of physical pressures, and Banks later wrote to Burney and Leso with a "strong recommendation … that you do not use physical pressures." [121] It is less clear what Banks' and Joint Personnel Recovery Agency's (JPRA) position was on psychological pressures such as isolation and sleep deprivation.

On October 2, 2002, the BSCT wrote a memo requesting authorization to use additional interrogation techniques. "Category II techniques" included stress positions; the use of isolation for up to 30 days (longer periods could be authorized by the chain of command); deprivation of food for 12 hours; handcuffing; hooding; and consecutive 20-hour interrogations once a week. "Category III" techniques included daily 20-hour interrogations; isolation without access to medical professionals or the ICRC; removal of clothing; exposure to cold or cold water; and "the use of scenarios designed to convince the detainee he might experience a painful or fatal outcome." [122]

The October 2 BSCT memo also made recommendations about harsher conditions in the cell blocks, stating that "all aspects of the [detention] environment should enhance capture shock, dislocate expectations, foster dependence, and support exploitation to the fullest extent possible." It proposed that detainees who were not cooperating with interrogators receive only four hours of sleep a day; be deprived of sheets, blankets, mattresses, washcloths; and that interrogators control access to their Korans.[123]

"Al Qahtani was interrogated for approximately 20 hours a day for seven weeks ... "

Even as it requested authorization to use these techniques, the October 2 memo recommended against their use. This was partially on grounds of efficacy and the danger of false confessions, but the BSCTs also warned:

> The interrogation tools outlined above could affect the short term and/or long term physical and/or mental health of the detainee. Physical and/or emotional harm from the above techniques may emerge months or even years after their use. It is impossible to determine if a particular strategy will cause irreversible harm if employed.[124]

Burney told the Senate Armed Services Committee that he and his colleagues requested authorization to use the techniques despite this warning because there was "a lot of pressure to use more coercive techniques," and any memo that did not request them "wasn't going to go very far." [125] The BSCTs' warning about the dangers of the techniques was removed when their proposal for coercive techniques was transmitted up the chain of command.[126]

Also on October 2, Burney and Leso participated in a meeting with interrogation personnel, legal advisor Diane Beaver, and CIA attorney Jonathan Fredman. According to Beaver's minutes, the BSCTs discussed Mohammed al Qahtani's response to "certain types of deprivation and psychological stressors." [127]

Al Qahtani, detainee number 63, was suspected of being the intended 20th hijacker in the September 11 attacks. In October 2002, he was interrogated with military dogs present, deprived of sleep, and placed in stress positions, all while in isolation.[128] When this failed to yield intelligence, Joint Task Force 170 (JTF-170) halted the interrogation and began developing a new "Special Interrogation Plan." Al Qahtani remained in isolation, however, and according to an FBI agent by the end of November he was "evidencing behavior consistent with extreme psychological trauma (talking to non-existent people, reportedly hearing voices, crouching in a corner of the cell covered with a sheet for hours on end)." [129]

A publicly released interrogation log, dated from November 23, 2002, to January 11, 2003, shows that his treatment only became harsher.[130] Al Qahtani was interrogated for approximately 20 hours a day for seven weeks; subjected to strip searches, including some in the presence of female interrogators; forced to wear women's underwear; led around on a leash; made to bark like a dog; and subjected to cold temperatures. Al Qahtani was also forcibly injected with large quantities of IV fluid and forced to urinate on himself, and given repeated enemas. (According to the log, this was due to al Qahtani's refusal of fluid and constipation, but interrogators also used the prospect of being given IV fluid and enemas as a threat.) On December 7, 2002, al Qahtani's heartbeat slowed to 35 beats per minute, and he had to be taken to the hospital for a CT scan of his brain and ultrasound of a swollen leg to check for blood clots.[131] On December 13, al Qahtani's pulse again slowed to 38 beats per minute, but when it rose to 42 beats per minute a doctor determined that no medical intervention was necessary.[132] His interrogation log also showed rapid fluctuations in weight, possibly due to forcible hydration.[133] The log makes multiple references to swelling of the hands and feet, and to al Qahtani needing bandages due to chafing from hand and leg cuffs.[134] The log also describes al Qahtani's psychological condition deteriorating. There are frequent references to al Qahtani crying,[135] and some entries suggest possible hallucinations.[136]

The log makes several references to the presence of a BSCT, and two to "Maj. L" — likely Major John Leso. It states that at one point when al Qahtani began crying, "[t]he BSCT observed that the detainee was only trying to run an approach on the control and gain sympathy," and at another point the BSCT member suggests putting him in a swivel chair to ensure he does not fall asleep.[137]

According to a January 2005 sworn statement from a member of the BSCT team with the rank of major (likely Burney or Leso), "through all of the interrogation with AL QATANEE, at least one of the members of the BSCT was always present and witnessed his interrogation. Cumulatively this logged hundreds of hours of observations." [138] The BSCT stated that the interrogation techniques used had been approved by commanders, and that both General Michael Dunlavey and General Geoffrey Miller believed that "coercive methods would be the best method of collecting information if given enough time. One of Gen. Miller's favorite quotes was, 'We've got more teeth than they have ass.' " [139]

Asked whether he felt that detainees were abused while he was at Guantánamo, the BSCT member replied,

> That is a hard question to answer. I do believe it is possible for some detainees to have some kind of long-term or unintended difficulties because of the interrogation practices, but I did not see detainees being subjected to pointless cruelty.[140]

Gelles and two of his colleagues at NCIS, Mark Fallon and David Brant, disagreed. They showed Navy General Counsel Alberto Mora extracts of the al Qahtani interrogation log as well as memos approving harsh techniques. Mora's reaction was, as he later described it, "dismay," [141] as discussed in greater detail in Chapter 1.

Colonel Larry James, who succeeded Leso as a BSCT psychologist at Guantánamo, has written that Leso's role in interrogations took a personal toll on him. According to James, when he arrived to relieve Leso in January 2003, he found that Leso was "traumatized" and "devastated" because:

> He witnessed many harsh and inhumane interrogation tactics, such as sexual humiliation, stress positions, detainees being stripped naked, and the use of K-9 dogs to terrorize detainees. He had no command authority, meaning he felt as though he had no legal right to tell anyone what to do or not do.[142]

Nevertheless, James believed that Leso "was successful in cutting back on some of the abusive practices." [143]

By his own account, James was able to do more by the time he left Guantánamo that May, teaching interrogators the effectiveness of lawful, rapport-building techniques and restricting their access to medical files. According to James, a Navy nurse explained to him that it was

> perfectly legal for any interrogator, regardless of rank, educational background, or age, to have legal open access to any detainee's medical record. What I discovered was that on any given day, FBI, CIA, Army, Navy, and contract interrogators would go to the hospital and demand to see detainees' records immediately.[144]

If the doctors hesitated, James wrote, interrogation personnel would "help themselves" to the records anyway. James said that he declared "that the hospital and all doctors and nurses were completely off-limits to anyone from the intel community" except the BSCTs. The BSCTs maintained access to this information, he said, "to eliminate the possibility that any ill or fragile detainee would be harmed as a result of some abusive interrogation technique." [145] James derided as "complete bullshit" ICRC and press reports that BSCTs were using medical records "in effect, to tell interrogators exactly where to poke the prisoner with a sharp stick." [146] But the ICRC's reports, well-documented cases such as the Jawad interrogation discussed below, and many other prisoners accounts suggest otherwise.

"If the doctors hesitated, James wrote, interrogation personnel would 'help themselves' to the records anyway."

It is plausible that conditions at Guantánamo improved on James's watch. Gelles noted improvements as well, though he attributed them primarily to Mora's intervention. Gelles said that in the short run the DOD decided not to go forward with the most coercive techniques being considered and "toned down" the next harshest category. In the long run, they realized that coercion "didn't work." [147]

There are credible reports, though, that neither abusive techniques nor BSCTs' role in coercive interrogations ended. In July 2003, Major General Miller submitted a request for approval for a "Special Interrogation Plan" for Mohamedou Ould Slahi, which was approved by Secretary Rumsfeld on August 13. [148] Interrogators apparently began implementing the plan before securing formal approval. They subjected Slahi to isolation, sleep deprivation, uncomfortable temperatures and darkness, threatened him with disappearance "down a very dark hole," and threatened to bring his mother to Guantánamo.[149]

The Senate Armed Services Committee uncovered documents suggesting that interrogators eventually became concerned about Slahi's mental state. On October 17, an interrogator emailed Lieutenant Colonel Diane Zierhoffer, a BSCT psychologist, that Slahi "told me he is 'hearing voices' now. … He is worried as he knows this is not normal. … [I]s this something that happens to people who have little external stimulus such as daylight, human interaction etc???? Seems a little creepy." [150] Zierhoffer responded that this was plausible: "[S]ensory deprivation can cause hallucinations, usually visual rather than auditory, but you never know…" [151] It is unclear what action she took, if any, in response to the report that Slahi was hallucinating. A Guantánamo prosecutor, Lieutenant Colonel Stuart Couch, eventually refused to prosecute Slahi because he concluded that his statements to interrogators were tainted by torture and coercion.[152]

Zierhoffer was later accused of encouraging interrogators to exploit a juvenile detainee, Mohammed Jawad, through a program of isolation and sleep deprivation. According to Jawad's military commission–appointed defense counsel David Frakt, a document obtained during the proceeding

> revealed the involvement of a BSCT psychologist in the interrogations of Jawad and strongly suggested that she had been directly responsible for some of the abuses that he experienced and that led to his suicide attempt in December 2003. I attempted to call this Army psychologist as a witness, but the prosecution informed me that the officer had invoked her right against self-incrimination and refused to testify.[153]

News reports identify Zierhoffer as the psychologist in question.[154] Jawad was eventually acquitted and released, in part due to the military commission's finding that his incriminating statements were the product of coercion.

Several Guantánamo detainees have alleged that doctors or psychologists administered psychotropic drugs for purposes of interrogation. A DOD inspector general's report on these allegations, released in response to a Freedom of Information Act request filed by Task Force staff, and others found that detainees had not been administered drugs for interrogation purposes. However, the same report found that detainees who were diagnosed with schizophrenia and psychosis received involuntary injections of Haldol and other powerful antipsychotics, and were interrogated while experiencing the effects of this treatment.[155] This raises questions about the reliability of those detainees' statements under interrogation.

The ICRC reported after a January 2003 visit to Guantánamo that the "cumulative effects of isolation, repeated interrogation," overly harsh detention conditions and harassment were a "major cause of deterioration of mental health" of detainees. By June 2004, the regime had become "more refined and repressive," and had been applied for so long, with the clear purpose of gaining intelligence, that the ICRC characterized it as "tantamount to torture." Detainees showed four times the rate of psychological distress as U.S. personnel. They did not trust doctors or mental health clinicians because they correctly believed that they would not keep their communications confidential, and sometimes there were health personnel present in interrogations. The ICRC reported that files were "literally open to interrogators," in "flagrant violation of medical ethics." [156]

According to the ICRC, most detainees were locked up 24 hours a day, and a quarter were in solitary confinement. A new unit called Camp 5, consisting of 112 isolation cells with solid walls of concrete, steel, and aluminum, was constructed in early 2004, and detainees were often kept there for extended periods. Other interrogation techniques included shackling in uncomfortable positions; altered or shortened sleep schedules; exposure to loud noise, music, and cold temperature; and some beatings.[157]

In 2005, Dr. Steven Sharfstein, president of the American Psychiatric Association visited Guantánamo after reading disturbing reports on mental health clinicians' role in interrogations. He met with some of the BSCTs and discussed their work. Sharfstein described them as "two young women, very nice. … I don't think they were malevolent in any way," and "the issue wasn't so much abuse when I was down there." Nonetheless, what he heard about their role made him uncomfortable, because they were clearly "part of the interrogation team" rather than clinicians. As he understood it, by that time the BSCTs were "not in the room, but in real time communication with the interrogators" whom they advised.[158]

BSCTs in Iraq and Afghanistan

Much less is known about health and mental health professionals' role in interrogation in Iraq and Afghanistan, but it is clear that in some cases BSCTs were used, and that interrogators had broad access to medical records.

Colonel James recounted conversations with the chief Army SERE psychologist, Colonel

Morgan Banks, shortly after the Abu Ghraib scandal became public, in which Banks told him that part of the problem was "[w]e don't have a biscuit psychologist at that place," [159] and assigned James to deploy there. But while there may have been no BSCT at Abu Ghraib when the scandal broke, there had been a psychiatrist assisting with interrogations for part of the period when the abuse photographs were taken.

From August 31 to September 9, 2003, Guantánamo commander Major General Geoffrey Miller led a team of interrogation personnel to assess intelligence gathering in Iraq. One of Miller's findings was that interrogators in Iraq should have access to a BSCT.[160] On November 15, 2003, Major Scott Uithol, a psychiatrist, reported to Abu Ghraib to fill that role.[161] He served with the 205th Military Intelligence Brigade for the next month. When he arrived, "I didn't know what a Biscuit was," he later told Dr. M. Gregg Bloche.[162]

Another source has described a psychiatrist having a role in interrogation at Abu Ghraib. Colonel Thomas Pappas, the commander of the 205th Military Intelligence Brigade, said that a doctor and psychiatrist would evaluate detainees' written interrogation plans and "have the final say as to what is implemented." According to Pappas, the psychiatrist would also sometimes go in with interrogators to evaluate detainees "and provide feedback as to whether they were being medically and physically taken care of." [163]

JPRA instructor Terrence Russell, who advised Special Forces troops at Camp Nama about SERE techniques in September 2003, has described a discussion about the use of "physical pressures" in interrogation with the "TF-20 SERE psychologist." [164] A criminal investigative file from May 2004 contains an allegation from an interrogator who reported abuses by Special Forces task forces at Camp Nama, near the Baghdad airport. The interrogator said he "felt the actions were inhumane even though every harsh interrogation was approved by … the medical personnel prior to its execution." [165]

A 2005 DOD investigation by the inspector general of the Navy, Admiral Albert T. Church, reported that,

> [a]nalogous to the BSCT in Guantánamo Bay, the Army has a number of psychologists in operational positions (in both Afghanistan and Iraq), mostly within Special Operations, where they provide direct support to military operations. They do not function as mental health providers, and one of their core missions is to support interrogations.[166]

Church found, based on interviews with clinicians in both Iraq and Afghanistan, that interrogators sometimes had easy access to medical information. In several cases, medical information and reports from interrogations were kept in a single file, which Church noted "makes it impossible to control or even monitor access to detainee medical information." [167]

Medical Personnel and Abuse Reporting

There have been allegations about medical personnel failing to report and document abuses in Iraq and Afghanistan.

A 2005 report by the U.S. Army surgeon general found that during the period when the most

intense abuses were committed against detainees at Guantánamo, Iraq and Afghanistan, from 2001 to 2004, there were no rules that specified health professionals' obligations to report abuse or any mechanisms to do so. Army policies requiring reporting were not issued until late 2004, and specific procedural directives for units were not available until late 2004 and early 2005. [168] Clinicians were not regularly informed or trained on the duty to report abuse until then, and only 37 percent of previously deployed medical personnel understood that they had a duty to report suspected cases of abuse.[169] In 2005, after receiving training, the number of medical personnel who said a detainee had alleged abuse to them quintupled, from 5 percent to 25 percent — despite widespread testimony that the worst abuses occurred before the Abu Ghraib scandal and the new guidance on reporting.[170]

The surgeon general's report was based on an investigation conducted between November 2004 and April 2005 involving interviews of military medical personnel, including physicians, nurses, and non–health professional personnel such as medics and technicians in various training settings and theaters of operation.

Of 60 medical personnel assigned to detention operations in Afghanistan who were interviewed for the surgeon general's report, only one claimed to have observed abuse or had an allegation of abuse reported to him or her.[171] At Guantánamo Bay, among the seven interviewed, no previously deployed and only two currently deployed medical personnel surveyed claimed to be aware of any abuse.[172] FBI agents assigned to Guantánamo in 2002, by contrast, repeatedly reported witnessing abuse and raised their concerns to the highest levels of the agency.[173] In some cases there seems to have been overt pressure on clinicians not to report suspected abuse. The surgeon general's report, for example, notes that one interviewee stated that

> on two separate occasions, he was pressured by OGA personnel into filling out death certificates on Iraqi Detainees. Stated he was not given the opportunity to examine the dead. Causes of death were later found to be inaccurate.[174]

Despite these findings, the surgeon general's report concluded that medical personnel were "exceptionally vigilant in reporting actual or suspected detainee abuse." [175]

Major General George Fay's August 2004 report into abuses at Abu Ghraib found evidence of two medics (not physicians) witnessing and failing to report abuse at Abu Ghraib in November and December 2003. Fay also found that, more generally, "medical personnel may have been aware of detainee abuse at Abu Ghraib and failed to report it," but could not draw conclusions about the full scope of this problem because they had "requested, but not obtained" detainees' medical records. The Fay report noted that detainee medical records likely were not being maintained in accordance with Army regulations.[176] A number of criminal investigative files in other cases reviewed by Dr. Steven Miles contain evidence of medical signs of abuse going unreported or uninvestigated.[177]

Problematic record-keeping, and failure to report suspicions of abuse, extended to homicides. In several cases, prisoners were initially reported to have died of natural causes when their deaths actually resulted from abuse. The death of Iraqi Major General Abed Hamed Mowhoush is one example. An initial Pentagon press release about Mowhoush's death stated that "Mowhoush said he didn't feel well and subsequently lost consciousness. The soldier questioning him found no pulse, then conducted CPR and called for medical authorities. According to the on-site

surgeon, it appeared Mowhoush died of natural causes." [178] A later autopsy, however, revealed that Mowhoush had died of asphyxia and chest compression after an interrogator stuffed him into a sleeping bag and sat on his chest. He had suffered "massive" bruising on his torso, arms, and legs (though not his head or face), and five broken ribs.[179]

Army pathologists found the death of Nagem Sadoon Hatab near Nasariya on June 5, 2003, to be a homicide caused by strangulation. However, the body was not properly refrigerated before or after the autopsy, and body parts were lost due to a "miscommunication" between the doctor who examined the body and her assistant. As a result, a military judge excluded the medical evidence of the cause of Hatab's death, and efforts at prosecution collapsed.[180] The investigation of another suspicious case, Abdul Malik Kenami's death in Mosul in December 9, 2003, was closed without any autopsy being performed at all.[181]

Vincent Iacopino of Physicians for Human Rights and retired Brigadier General Stephen Xenakis, M.D., reviewed the medical records of nine Guantánamo detainees who had alleged abuse. Xenakis and Iacopino found that all of the allegations were credible. In three cases, the detainees had physical injuries that were "consistent or highly consistent" with allegations of abuse, including bruises, lacerations, bone fractures, nerve damage, and sciatica, with "no mention of any cause for these injuries." Eight of the nine detainees suffered psychological symptoms, including nightmares in five cases; suicidal ideation in four cases and suicide attempts in two; depression in two cases; dissociative states in two cases; and hallucinations in three cases. These symptoms were correlated in time with detainees' allegations of abuse. However, "[t]he medical doctors and mental health personnel who treated the detainees at GTMO failed to inquire and/or document causes of the physical injuries and psychological symptoms they observed." [182]

Hunger Strikes

Hunger Strikes and Force-feeding at Guantánamo

One of the most controversial aspects of medical personnel's treatment of detainees has been their role in force-feeding prisoners on hunger strikes. Detainees at Guantánamo have used hunger strikes to protest their confinement since shortly after the camp opened, in February 2002. The first reported incidents of detainees being force-fed occurred in May 2002, after 60 or 70 days of hunger strikes.

The largest wave of hunger strikes began in the summer of 2005. The strike began on August 8, and by September 131 detainees were refusing food. An increasing number of them were fed involuntarily. In October 2005, prison officials told a delegation of visiting medical organizations that 25 prisoners were currently on a hunger strike, 22 of whom were being fed by nasogastric tube, most while in their cells and almost all of them acquiescing to the procedure.[183]

Detainees, through their lawyers, filed motions asking federal courts to stop the involuntary feeding, which they claimed was carried out in a punitive, brutal fashion. They alleged that doctors used excessively large feeding tubes that made inserting and extraction extremely painful, and causing bleeding, vomiting and loss of consciousness in some cases.[184]
Sami al-Hajj, a journalist who heads the Liberties and Human Rights Affairs section of Al Jazeera, was held for nearly seven years in Afghanistan and Guantánamo. At Guantánamo,

he undertook a 480-day hunger strike, during which he was force-fed by the military.[185] In an interview with Task Force staff, al-Hajj described his force-feedings as punitive exercises:

> They're supposed to feed you [with] two cans, small cans … but they feed us 24 cans and 24 bottle of water, continuous. And we [were] throwing up, it continues and we throwing up and it continues. This is one feeding; [it] would take 8 hours like that, you are in chair. Until your cell become full of [vomit]. And after that, when they come and [remove the feeding tube from the esophagus], they [would grab the tube and just walk away with it]. Then there was blood coming. And [the guard] takes it from you and he goes to another [detainee] directly and [inserts it] … without cleaning.[186]

An October 19, 2005, declaration from Captain John Edmondson, then commander of Guantánamo's hospital, denied that force-feeding was intended to punish detainees. "Medical personnel do not insert or administer nasogastric tubes in a manner intentionally designed to inflict pain or harm on the detainee," Edmondson said, but

> whenever nasogastric tubes are used, there may be occasional minor bleeding and nausea as a result. … Occasional sores may occur in the throat, but those sores have not been severe and have been treated. The sores have not kept the patients from talking or otherwise functioning within the camp or the detention hospital. In all of the procedures done in order to feed patients enterally during the hunger strike, only one patient has passed out, and that was due to hyperventilation.[187]

Edmondson emphasized that once the feeding tube was inserted, "the detainee himself controls the flow of nutrition so that any discomfort is minimized," and that detainees were generally able to move around their cells during a feeding. He noted that feeding schedules had also been changed to accommodate detainees' fast during Ramadan. [188]

On November 10, 2005, Captain Stephen Hooker succeeded Edmondson as the officer in charge of the medical staff at Guantánamo, and determined that detainees were being given too much control over their feeding. In a sworn declaration, Hooker alleged that

> [t]here were several small violent group demonstrations in the Detention Hospital by the hunger strikers. … The doctors, nurses, and medics, were commonly verbally and physically assaulted, including being spit upon and having urine thrown on them. The prior Officer-in-Charge of the Detention Hospital was spit upon and had urine thrown on him. Two nurses were punched in the face.[189]

Hooker stated that despite being fed involuntarily, detainees were increasingly malnourished, because they were "sabotaging the feeding efforts" by negotiating for less formula or deliberately vomiting after a feeding.[190] By December 15, 19 of 29 hunger strikers being force-fed "had become significantly malnourished (less than 75% of their Ideal Body Weight) and were at great risk for serious complications." [191]

In December of 2005, a forensic psychiatrist and three consultants from the Federal Bureau of Prisons (BOP) visited Guantánamo and made recommendations for changing the hunger strike

protocol. According to Hooker, they all recommended the use of a "restraint chair" for enteral feedings.[192] The restraint chair was manufactured by a small company in Iowa, ERC Inc., which shipped five chairs to Guantánamo in early December and 20 more on January 10, 2006. The company's website advertises the chairs as a useful tool for safe confinement or transportation of a "combative or self-destructive person. … It's like a padded cell on wheels." [193] The chair completely immobilizes a person strapped into it, using a lap belt and straps that immobilize the head as well as wrist and ankle restraints.

"Saudis Ahmed Zuhair and Abdul Rahman Shalabi, were force-fed daily for close to four years."

Dr. Emily Keram, who did a medical evaluation of hunger striker Ahmed Zuhair in 2009, recounted his allegations:

> When the restraint chairs were first introduced Mr. Zuhair was kept in the restraint chair for two hours after feeding ended. His requests to use the bathroom were refused. He soiled himself with urine and feces. Guards started putting diapers on Mr. Zuhair, refusing to allow him to do this himself. Some detainees ended their hunger strike. Mr. Zuhair was once kept in a restraint chair for six hours, exceeding the two hour maximum time limit recommended for the detainee's safety. … Mr. Zuhair expressed his conviction that the restraint chairs were introduced as a means of punishing hunger striking detainees and forcing them to end their hunger strikes.[194]

By the end of December 2005, only four or five detainees (including Zuhair) were still on hunger strike.

The military has maintained, in a series of sworn declarations by Guantánamo commanders and medical officers, that the use of the restraint chair for force-feeding is not a form of punishment of, or retaliation against, detainees. Rather, its use was modeled after procedures used in U.S. federal prisons that visiting officials from the BOP had recommended that Guantánamo adopt. Force-feeding was only used "when medically necessary," and detainees are kept in restraint chairs for "approximately 120 minutes or less," twice a day.[195] In a declaration filed on May 13, 2006, Major General Jay Hood acknowledged that detainees had soiled themselves in restraint chairs, but portrayed this as an attempt at manipulation:

> Since we began using the restraint chair system, over 700 meals have been fed to 29 detainees. In all of those feedings, records establish that only four detainees have urinated or defecated for a total of 20 occasions. Once these few detainees found that the tactic of soiling the chair would not work to delay their feeding, the incidents ceased.[196]

Although most detainees ended their hunger strikes when the restraint chairs were introduced in 2005, a few did not. At times, the number of hunger strikers being fed in restraint chairs rose to several dozen. Two detainees, Saudis Ahmed Zuhair and Abdul Rahman Shalabi, were force-fed daily for close to four years. After suffering serious medical complications from their prolonged fast and the force-feeding, both were evaluated by outside doctors in 2009. Zuhair and Shalabi both stated that while not as brutal as when it was first introduced, the feeding chair made them feel "like an animal," and caused physical pain and hemorrhoids due to pressure on the tailbone.[197] Both expressed a very strong preference for being tube-fed in a hospital bed,

even in restraints. The evaluating psychiatrist, Dr. Emily Keram, found that Zuhair was suffering from some symptoms of anxiety, depression, and post-traumatic stress disorder (PTSD) that were worsened by the restraint chair, though these did not rise to the level of full blown PTSD or major depression.[198] She found that Shalabi suffered from full-blown PTSD, triggered in part by the restraint chair.[199] She recommended that both be fed in hospital beds.[200]

Keram observed Zuhair's force-feeding in the restraint chair in January 2009. She stated that medical staff complied with the guidelines for using the restraint chair. She also interviewed medical staff and guards, who did not express a hostile or punitive attitude toward the hunger strikers; one told her: "It's their decision. It's like smoking." Keram noted, though, that "[r]estraint chairs were used for all detainees' enteral feedings, regardless of their disciplinary history, unless there was a medical contraindication. … There was no behavioral reward system by which a detainee could work his way up to another venue." The guards and the deputy commander of the detention group at Guantánamo told her that they did not know why compliant detainees could not be fed in hospital beds.[201]

The rationale given in a 2007 declaration by Captain Ronald Sollock was that even when a detainee was compliant,

> there is simply no way to tell if or when he will become uncompliant and violent again and threaten the safety and welfare of the Detention Hospital medical staff. Accordingly, the use of the restraint chair is required.[202]

Many medical ethicists view any form of force-feeding as unethical. The World Medical Association's 1975 Declaration of Tokyo, strongly endorsed by the American Medical Association (AMA), states that "[w]here a prisoner refuses nourishment and is considered by the doctor 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." [203] The same organization's Declaration of Malta, adopted in 1991 and revised in 2006, contains more extensive and detailed policies on force-feeding. The Declaration of Malta notes that physicians must ensure that prisoners are competent and their refusal of nourishment is voluntary, and does not result from peer pressure, but concludes that "forcible feeding is never ethically acceptable." Regarding end-of-life issues, the Declaration of Malta states: "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. … 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." [204]

Despite this, the BOP has adopted a policy of involuntarily feeding prisoners in some circumstances, which is codified in the Code of Federal Regulations and has been upheld by U.S. courts. Federal prisons are known to use restraint chairs for inmates who are physically dangerous to themselves, other inmates, or guards, but at most federal prisons, the chairs are apparently not used for forced feeding.

Based on those facts, and the government's affirmation that the use of the restraint chair for enteral feeding was modeled after procedures in federal prisons, Judge Gladys Kessler of the U.S. District Court for the District of Columbia upheld the force-feeding procedure in 2009.[205] A 2009 DOD review of conditions of confinement at Guantánamo, ordered by the Obama

administration, similarly found that the use of restraint chairs for force-feeding was "lawful and humane" in part because the process "is similar to that used by the US Bureau of Prisons, and has been upheld in US federal courts." [206]

But at least some federal prisons handle hunger strikes very differently, and far less coercively, than at Guantánamo. In 2007, federal prisoner Sami al-Arian went on a water-only hunger strike for 60 days. Near the end of the strike, his family reported that his weight dropped from 202 pounds to 149 pounds, he was unable to walk, and trembled constantly. He was transferred to a medical prison, but was not force-fed, though BOP spokesmen publicly said officials considered doing so.[207] In contrast, based on court documents and press reports about the Guantánamo hunger strikes, detainees have been force-fed in a matter of days or weeks after they start refusing meals — long before their lives were in serious danger.

The written federal guidelines for force-feeding make no mention of restraints, and include several safeguards that are not in place in Guantánamo. Prison guidelines require the warden to notify a sentencing judge of involuntary feeding, with an explanation of the background of and reasons for involuntary feeding, as well as videotaping of force-feeding. BOP requires that "treatment is to be given in accordance with accepted medical practice." [208] Accepted medical practice requires an individualized assessment of the patient's situation that appears to be absent at Guantánamo. It also requires individualized counseling of the detainee, but based on medical records Guantánamo that "counseling" is frequently limited to a boilerplate warning about the dangers of hunger strike.

The BOP's written policy on the use of restraints also conflicts with the restraint-chair protocol at Guantánamo. In federal prisons, restraints can be used "to gain control of an inmate who appears to be dangerous because the inmate is assaulting another individual, destroying government property, attempting suicide, inflicting injury upon himself or herself, or displaying signs of imminent violence." [209] The use of four-point restraints must be authorized by the prison warden if he finds that they are the "only means available to obtain and maintain control over an inmate," and he cannot delegate this decision. In general, restraints are to be used "only when other effective means of control have failed or are impractical," and are to be removed when an inmate exhibits self-control.[210] The regulations make no provision to routine or categorical use in cases, regardless of an individual inmate's behavior, or the use of restraints in force-feeding. There is no generalized written policy on the use of the restraint chair, but according to the United States' 2005 report to the Committee Against Torture, "[BOP's] use of restraint chairs is intended only for short-term use, such as transporting an inmate on or off of an airplane." [211]

At least one federal prison has used restraint chairs for force-feeding: ADX Florence, the highest security federal prison in the United States. Press reports frequently refer to the Florence "Supermax" as "the Alcatraz of the Rockies," and describe it as the most secure prison in the world.[212] Inmates are sent there if they cannot be safely housed at other maximum security prisons. Many have been convicted of terrorist attacks, mass-murders, or murders of guards or other inmates at other prisons.

One former warden at Florence, Robert Hood, told CBS News that he had authorized over "350, maybe 400" involuntary feedings of inmates, and CBS found records of 900 involuntary feedings in the prison's H-wing, which houses convicted terrorists. (As Hood told CBS, the

number of individual prisoners force-fed is likely much lower, because "you could have one person, three meals a day for, you know, two months. That adds up.")[213] According to Laura Rovner, a clinical law professor who represents several ADX inmates, use of the restraint chair to force-feed inmates is "a pretty widespread practice" at the Florence Supermax. The government has redacted descriptions of the process in court documents, so details of the procedure are unknown. Rovner said that two safeguards that do exist are requirements to notify a prisoner's sentencing judge, and to videotape the force-feeding process.[214]

It is unclear when the use of restraint chair began in Florence. An August 2006 OLC memo by Steven Bradbury refers to a recent "coordinated hunger strike among several convicted al Qaeda terrorists" held at ADX Florence, in which terrorists "developed a sophisticated method to resist compulsory feeding." [215] The Bradbury memo does not give a specific date for that hunger strike, however.

Hunger strikes and force-feeding in the restraint chair continue to this day at Guantánamo, as confirmed by a February 14, 2012, visit to the base by Task Force staff. A PowerPoint displayed to visitors who tour Guantánamo lists hunger strikes as a means of detainees "continuing the fight." According to veteran Guantánamo correspondent Carol Rosenberg of *The Miami Herald,* as of March 19, 2013 the military acknowledged there were 24 prisoners on hunger strike. Eight of them were being force-fed in restraint chairs.

Ideal Management of Hunger Strikes

The involvement of physicians is essential for the management of hunger strikes. Their roles include: recognition and diagnosis of the hunger strike; assessment of the competence of the individual, whether the individual is suicidal, or whether there is pressure or coercion from other detainees involved; informing and advising the hunger striker regarding expected medical developments and outcomes and making decisions about management; treating and dealing with medical issues during the course of the fast; managing periods of refeeding after fasting; and dealing with medical crises and terminal, end-of-life situations. The physician should be involved as the hunger striker's physician, in a trusted, physician-patient relationship with the individual's medical interest held as paramount.

During the course of the hunger strike, serious medical situations may arise that call for feeding or the provision of nutrition by other means to prevent permanent injury or death. Such situations are most likely to occur at the end of a prolonged hunger strike. Total fasting with ingestion of water may go on for weeks and months without immediate risk of permanent injury or death, which usually occurs 55–85 days from the onset of fasting.[216]

At those times, in the context of continued determination of competence and absence of suicidal intent, physicians should advise the individual of the medical situation and the need for feeding or other forms of nutrition. The competent, nonsuicidal individual may elect to continue the fast or alter it by agreeing to some form of supplemental nutrition. If the physician determines that the striker is no longer competent, the physician, in the absence of advance directives to the contrary, may elect to proceed with feeding or nutrition. In such circumstances, the administration of nutrition or feeding without the consent of the individual is termed involuntary or force-feeding.

If hunger strikers are strong enough to physically resist forced feeding, it is unlikely that they are near death. Forced feeding is medically uncalled for in such situations.

Prolonged hunger strikes that proceed to the point of the likelihood of permanent injury or death pose challenging situations for all. The hunger striker may have maintained the commitment to fast understanding the possibility of death — a commitment that should be repeatedly examined and documented during the course of the hunger strike. Even though the individual may not, at the end, be competent or capable of reiterating that commitment, it may have been clearly expressed in an advance directive document declared at a previous time when the individual was competent and not suicidal. If no such directive exists, the physician is left to interpret the individual's wishes. At that point, acting on behalf of the best interest of the individual, the physician may elect to institute or recommend the administration of nutrition. If an advanced directive exists, the administration of nutrition would be contrary to the directive with medical and presumably ethical implications. Reportedly, in some cases physicians have elected to proceed with or recommend feeding. At such times, all such decisions should involve those responsible for the setting or institution. It is at this point also that the responsible institution, *e.g.*, a detention center, may elect to order feeding.

Analysis of Ethical Obligations of Health Personnel Toward Detainees Undergoing Interrogation

The Ethical Obligations of Medical Professionals Toward Detainees

Health care professionals — whether they are psychiatrists, other physicians, physicians' assistants, psychologists, or nurses — have certain obligations to people under their care. The most famous statement of these obligations is the approximately 2000-year-old Hippocratic Oath, which promises in part, "In every house where I come, I will enter only for the good of my patients."
Most medical students recite some form of the oath before their graduation. Modern ethics codes reiterate the fundamental obligations to do good, and not harm, to patients; to respect patients' autonomy and not impose treatments without their consent; and to safeguard their confidences.[217] Psychologists and other health professionals share these obligations, though they do not formally recite the Hippocratic Oath.[218]

In keeping with these principles, doctors are forbidden from using their professional knowledge to help inflict torture or cruelty on anyone. The World Medical Association's (WMA) Declaration of Geneva is a physician's oath, adopted in the wake of revelations about atrocities by Nazi doctors, that promises "even under threat, I will not use my medical knowledge contrary to the laws of humanity." [219] The WMA's Declaration of Tokyo, adopted in 1975, states that a 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 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." The Declaration of Tokyo further forbids doctors from being present when torture is inflicted or threatened, or providing any "premises, instruments, substances or knowledge to facilitate the practice of torture. … A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible." [220]

In 1982, the U.N. General Assembly adopted similar principles that applied to all health personnel, though with particular force to physicians, stating in part, "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." [221] The same document specifically forbids health personnel from participation in

> any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.[222]

The American Psychological Association and American Psychiatric Association adopted a joint resolution supporting these principles in 1985.[223] The American College of Physicians similarly stated in its 1992 ethics manual, "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." The AMA adopted the following policy in December 1999:

> Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, 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 best 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.

Separation of DOD and CIA Medical Personnel from Their Professional Ethical Obligations

Soon after September 11, the military adopted a policy that key professional obligations, including the duty not to harm, do not apply in situations where the health professional has no clinical relationship with the patient. Current military guidelines claim that only medical personnel "*charged with the medical care of detainees* have a duty to protect detainees' physical and mental health and provide appropriate treatment for disease" [224] (emphasis added). Health personnel who do not provide these clinical services, the military asserts, only have an obligation to obey the law as it applies to detainees. In 2004, David Tornberg, then the deputy assistant secretary of defense for health affairs, stated that when a doctor participates in interrogation, "he's not functioning as a physician." [225] In keeping with this position, the Defense Department changed key words in the U.N.'s standards of medical ethics in drafting its own standards for treatment of prisoners.[226] While the U.N. principles state that it is a contravention of medical ethics for a physician to have "any professional relationship" with prisoners 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." [227] As discussed further below, every professional medical association has rejected this distinction.

The DOD instruction governing medical support of detainee operations does not require health professionals who are not in a clinical relationship with detainees to preserve detainees' well-being and avoid harm. Instead, it refers only to 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 Department of Defense, 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." [228] This simply restates a requirement to refrain from potentially criminal acts of cruelty that applies to all service members.

The Department of Defense does not require that licensed health professionals in its employ adhere to the ethical standards set by their professional associations, stating:

> 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.[229]

Instead, the Army Medical Command and Office of the Surgeon General have made their own determinations about whether military health professionals' conduct complies with their professional obligations. The Office of the Surgeon General has determined that acting as BSCTs is an "ethical practice consistent with medical and psychological ethics," [230] and that,

> [a]lthough physicians who provide medical care to detainees should not be involved in decisions whether or not to interrogate because such decisions are unrelated to medicine or the health interests of an individual, physicians who are not providing medical care to detainees may provide such information if warranted by compelling national security interests.[231]

DOD asserts that these policies are consistent with an AMA call for "balancing obligations to society against those to individuals." [232] As discussed below, this is not accurate.

Far less is known about the CIA's ethical guidance concerning the role of medical and mental health personnel in interrogation and detainee treatment, due to the level of secrecy that surrounds the program. The only available documentation of the CIA's policies are the OMS guidelines discussed above, which outline a role for clinicians that clearly conflicts with their professional obligations. The alleged participation of "psychologists/interrogators" in *administering* brutal techniques like waterboarding is an even clearer conflict.

Doctors and psychologists serving in the field were forbidden from revealing what was happening, or discussing these issues with civilian practitioners. Even those disturbed by abusive interrogations could not discuss their objections outside the chain of command. As Gelles stated, "it was classified. …There are laws about talking about classified information in unclassified arenas."

Because of these restrictions, the medical and mental health professions had little awareness of widespread U.S. mistreatment of detainees before Abu Ghraib. There was even less knowledge

of the role of medical and mental health professionals in that treatment. The first reports of clinicians' complicity in abuse at Guantánamo were published in late 2004, and the military vehemently denied them. The corroborating evidence emerged over the course of several years. James Mitchell's and Bruce Jessen's role in designing the CIA interrogation program was not reported until 2007, and the official documents confirming clinicians' essential role in the CIA program were released still later.

Revisions to Professional Guidelines Regarding Participation in Abuse After September 11

When clinicians' role in abusive interrogations did become public, the American College of Physicians, American Medical Association, and American Psychiatric Association reacted with dismay. All three associations rejected the government's argument that medical professionals advising interrogators were not acting as doctors and were exempt from their normal professional ethical standards. Instead, they further tightened their restrictions, to forbid members from participating in any interrogation.

In November 2005, the American College of Physicians wrote to the Department of Defense, rejecting the distinction DOD drew between doctors who "have a provider-patient treatment relationship" with detainees and those who do not, because "[t]his distinction leaves open the possibility for physician involvement in interrogations, which is inconsistent with ACP policy regarding the physician's role as healer and promoter of health and human rights." [233] In 2008, it revised its ethics manual to state more clearly that "[p]hysicians must not conduct, participate in, monitor, or be present at interrogations, or participate in developing or evaluating interrogation strategies or techniques." [234]

The American Psychiatric Association issued a formal resolution in 2006, declaring that physicians should not conduct, monitor or directly participate in the interrogation of prisoners or detainees, regardless of whether torture or abuse is occurring. The full resolution states:

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 in a position 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[235]

Dr. Sharfstein, former president of the American Psychiatric Association, said that psychiatrists found participating in interrogation "without the consent of individuals" in "highly coercive settings" to be incompatible with doctors' Hippocratic commitment to do no harm, and "the trust that people need to put into us." He said that while the controversy over Guantánamo was what prompted the resolution, the issue "when we thought about it … clearly was beyond just the war on terror." [236]

When the American Psychiatric Association adopted its position, Sharfstein noted that it was a position statement rather than an enforceable ethical rule, and assured military psychiatrists that they "wouldn't get in trouble with the APA" for following orders that violated it.[237] Dr. M. Gregg Bloche, a law professor as well as a psychiatrist, has criticized this assurance as a way for the psychiatric association to appear to take a strong position while signaling to the military that they would look the other way if psychiatrists continued to participate.[238]

In response to these criticisms, Sharfstein said, "We're a voluntary association. There is an ethics process" for complaints, but "the only sanction available" is to reprimand, sanction, or expel members from the association. In general, as soon as an investigation starts for any infraction, "they resign, and the only thing we can do is make public the fact that they resigned under investigation. … We don't have any police power like a licensing board." He said that the American Psychiatric Association's position was a philosophical position that would allow people in the military to say, when ordered to assist in interrogations, that it would be contrary to their professional ethical society's instructions, but "[w]hether that's effective or not, I don't know." [239]

A few months after the American Psychiatric Association's resolution, the American Medical Association adopted a very similar position. The AMA stated that:

(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.

In 2008, the American College of Physicians adopted the following statement:

> 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.

The World Medical Association revised its Tokyo Declaration to similar effect.[240]

In contrast to the medical association's ban on participation in interrogation, the American Psychological Association (APA) has taken the position that it can be ethical for psychologists to advise interrogators — a decision that many psychologists strongly oppose. In 2005, the APA's official Task Force on Psychological Ethics and National Security (PENS Task Force), while

reaffirming its opposition to any form of torture or cruel treatment, concluded that

> it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information-gathering processes for national security-related purposes. … [P]sychologists are in a unique position to assist in ensuring that these processes are safe and ethical for all participants.[241]

The PENS Task Force declined to "render any judgment concerning events that may or may not have occurred in national security-related settings" [242] Most of its other prohibitions contained similar caveats. The PENS Task Force found that psychologists had an ethical responsibility to report abuse to authorities, but made no recommendations about what actions to take if authorities failed to adequately respond. The PENS Task Force also recommended that APA members "guard against the names of individual psychologists [suspected of abuse] being disseminated to the public." Psychologists advising interrogators were forbidden from using "health care related information from an individual's medical record to the detriment of the individual's safety and well-being," but could use such information for other purposes, because it might be "helpful or necessary to ensure that an interrogation process remains safe." Psychologists were required to tell detainees that they were not acting as health professionals, and that the detainees should not expect confidentiality.[243]

The PENS report prohibits psychologists from engaging "in behaviors that violate the laws of the United States," but notes that "such rules and regulations have been significantly developed and refined" in the course of recent operations. It does not prohibit psychologists from violating international law (except to the extent that the "refined" version of U.S. law incorporates it), a deliberate omission.

The PENS report's conclusions, and the process preceded them, have led to years of bitter debate within the psychological profession and a number of resignations from the APA.

The PENS Task Force had nine voting members, whose identities and affiliations were kept confidential in advance of the report. [244] Six of the nine had some professional connection to the U.S. military or intelligence community.[245]

The three civilian members of the PENS Task Force have all expressed some degree of regret about their role in the group, although they had signed on to the original report. One member, Michael Wessells, resigned from the task force, and told reporter Amy Goodman that he regarded it as "predominantly a national security establishment operation" rather than a "representative dialogue" of psychologists.[246] Another, Jean Maria Arrigo, became so disillusioned with the report that she released her notes and the PENS email Listserv to the public despite a prior vote by task force members that the proceedings would be confidential.[247] She has been one of the leading voices calling for the report's nullification.

Before the report was finalized, the civilian members of the PENS Task Force were not aware of psychologists' central role in designing and implementing coercive interrogations. When Arrigo asked the group whether the APA should "exclude from membership psychologists who intentionally or negligently contribute to coercive interrogation," [248] Larry James wrote in response:

> it was psychologists who fixed the problems and not caused it. ***This is a***

> ***factual statement!*** the fact of the matter is that since Jan 2003, where ever [*sic*] we have had psychologists no abuses have been reported.[249]

Morgan Banks reassured Arrigo, in response to a question about potential offensive use of SERE techniques, that the Army's SERE school makes clear that it is illegal for U.S. forces to apply the techniques. Michael Gelles warned in general terms about potential ethical pitfalls for psychologists, but could not discuss the specific abuses that had occurred. Gelles said that he was comfortable with the PENS report, and his position has always been that "psychologists should be involved, no two ways about it. They should just have the appropriate training and the appropriate experience with the appropriate controls in play."[250]

Stephen Soldz, a psychologist at the Boston Graduate School of Psychoanalysis, was one of the founders of the Coalition for an Ethical Psychology, which opposes any participation of psychologists in interrogation. Soldz said in an interview that he regards the PENS report as "a rigged committee and a rigged process," and the product of an undisclosed relationship between the APA and U.S. intelligence agencies.[251]

In 2007, in response to critics of the PENS report, the APA passed a resolution specifying techniques that it considered torturous or cruel, and adopting the standards of the Geneva Conventions and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment. In 2008, it amended the resolution to address concerns about potential loopholes. The text currently bans

> mock executions; water-boarding 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.[252]

Also in 2008, APA members approved a referendum resolving that psychologists cannot work

> in settings where persons are held outside of, or in violation of, either International Law … or the US Constitution (where appropriate), unless they are working directly for the persons being detained or for an independent third party working to protect human rights.[253]

Eight-thousand, seven hundred and ninety-two APA members voted for the referendum, while 6,157 voted against.

Soldz does not consider these steps sufficient, and is still working to get the PENS report nullified. He stated, "what intelligence people told us over and over that what matters is having [psychologists] people there. Once there, they're under command, and they'll do what they're told," and cannot be effectively monitored because "it's classified." Soldz noted that neither the APA nor any state licensing board has ever acted on an ethics

complaint against psychologists.[254]

Complaints Against Individual Practitioners

In 2010, the APA wrote to the Texas State Board of Examiners of Psychologists regarding an ethics complaint filed against James Mitchell. The APA noted that Mitchell was not a member, but "[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" and referred to his state's licensing board with the "expectation that the individual's state license to practice psychology would be revoked." [255]

The Texas board dismissed the complaint against Mitchell after a hearing on February 10, 2011, at which Mitchell and his counsel were present. The board has not commented on the reasons for dismissal, saying it is legally forbidden from disclosing anything about a complaint that does not result in disciplinary action. Mitchell has told the press that the complaint against him was "riddled throughout with fabricated details, lies, distortions and inaccuracies," but gave no specific details because he was "not free to discuss any work I may have done for the CIA." [256]

Every other ethics complaint against a health professional in connection with post–September 11 abuses has likewise failed to result in disciplinary action, including complaints against John Leso in New York, Larry James in Louisiana and Ohio, Diane Zierhoffer in Alabama, and John Edmondson in California. The APA itself has not made any formal response to a complaint against Leso, which has now been pending for several years.

Michael Gelles, despite his differences with Leso, Mitchell, Jessen, and other advocates of "enhanced" techniques, fully supports the lack of any professional sanctions. Gelles said, "the fact that they're still chasing these psychologists in these ridiculous court cases, whoever files those suits should be disciplined." Gelles does support "the accounting of history," but not "an accountability of individuals." [257]

Others strongly disagree. The Texas complaint against James Mitchell noted that psychologists licensed in Texas are required to "report conduct by a licensee that appears to involve harm or the potential for harm to any individual, or a violation of Board rule, a state law or federal law." [258] Stephen Xenakis, a psychiatrist and retired Army Brigadier General, and Leonard Rubenstein, the president of Physicians for Human Rights (PHR), have called the failure to publicly investigate or discipline any health professional for involvement in torture "an unconscionable disservice to the thousands of ethical doctors and psychologists in the country's service." [259] PHR has advocated on behalf of legislation in Massachusetts and New York that would make it easier to sanction health professionals who participate in unethical treatment of detainees. [260]

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Whether or not the APA fully abandons the PENS report, there is a clear consensus within the medical and mental health professions that certifying that brutal interrogation techniques and conditions of confinement fall short of torture, or participating in interrogations like Abu Zubaydah's or al Qahtani's, are grave violations of professional ethics. Failing to report torture is equally unacceptable.

What is not clear is how to enforce these norms. Professional medical and psychological

associations do not have authority over licensure, nor do they have any authority over clinicians who are not members. They can investigate allegations against members, but remedies are limited — and the APA has declined to pursue such investigations. More importantly, state licensing boards have proved unable or unwilling to discipline the individual psychologists accused of abuses — likely because of the absence of clear rules and procedures that enable state boards to discipline doctors and psychologists for complicity in abuse, and the constraints of government secrecy. The identities of individual physicians, nurses or physicians' assistants who participated in the OMS's medical monitoring at CIA black sites have never been made public.