Doctors of Interrogation

BY JONATHAN H. MARKS

"We are busy with a little interrogation here. But our friend is taking some strain. He says he can't breathe properly. Could you just take a look at him? . . . [I]s he faking it? . . . In your opinion, as a doctor, how much more can he take?"

—*DAMON GALGUT*, THE GOOD DOCTOR

These questions were addressed to a young South African army doctor as he stood before a bruised man who was lying on the floor and breathing heavily. The doctor had been conscripted, given the rank of lieutenant, and assigned to a small field hospital near the Angolan border. Until that moment, his responsibilities had been limited to medical care: treating the sick or wounded. But now he had been summoned by the camp commandant to perform a different task, one that would haunt him for years to come. The doctor considered the questions "insane, . . . the measuring points of an inverted world" in which doctors are called upon, not to "heal and repair," but to assist in the "calculated demolition of nerves and flesh." But the glare of the commandant's "dead eyes" reminded the doctor what was being asked of him. He told himself: "The man on the floor is an enemy, who will in any case not last the night. It is myself I must look after." The doctor provided the assurance requested ("He won't die yet"), was amiably thanked for his advice, and permitted to depart. In the days that followed, his guilt was subdued by rationalization: "It would have made no difference. You didn't have a choice. You only answered the question."

This is a fictitious account of the so-called "dark art of interrogation" in the darkest days of Apartheid. But factual counterparts abound. There are numerous reports of real doctors in grim "inverted worlds" where they are no longer called upon to heal.[1] Most recently, there has been mounting evidence of physician complicity in abusive interrogation at Abu Ghraib and Guantanamo Bay.[2] These revelations give Galgut's story greater resonance. Voices that address the legal, ethical, and practical ramifications of physician involvement in interrogation are vital to any discussion of this topic. However, the voices of American physicians complicit in aggressive interrogations have—perhaps not surprisingly—been absent from the debate. Literature—which is neither muted by the fear of speaking out nor silenced by orders from superiors—may remind us what is at stake when we bring physicians into interrogation.

The Contours of Physician Participation

Although we do not yet have a complete picture of the involvement of physicians in interrogation at Abu Ghraib and Guantanamo Bay, its contours have been clearly sketched. We know that in late 2002, a behavioral science consultation team—an entity staffed by a psychiatrist and a psychologist and known colloquially as a "Biscuit"—was established in Guantanamo Bay to assist with the interrogation of detainees. We also know that in late 2003, another Biscuit was established at Abu Ghraib on the recommendation of Major General Geoffrey Miller—then camp commander at Guantanamo—who considered the team "essential in developing integrated interrogation strategies and assessing interrogation intelligence production."[3] At both facilities, one-way mirrors were installed that would have enabled medical personnel to monitor interrogations without being in the interrogation room.[4] And army records show that psychologists sometimes sat in on interrogations.[5]

Jonathan H. Marks, "Doctors of Interrogation," *Hastings Center Report* 35, no. 4 (2005): 17-22.

According to Colonel Thomas Pappas, head of military intelligence (MI) at Abu Ghraib, a physician worked alongside the psychiatrist. In his testimony to the Taguba inquiry, Pappas explained that military intelligence teams—also known as "tiger teams"—prepare individual "interrogation plans" for detainees, including a "sleep plan" and "medical standards," and that a "physician and psychiatrist . . . are on hand to monitor what we are doing."[6] He told the inquiry that "[t]he doctor and the psychiatrist . . . look at the files to see what the interrogation plan recommends" and added—perhaps seeking to legitimize the interrogation process or to pass the buck—that "they have the final say as to what is implemented."

To date, no interrogation or management plan has been made public. However, a number of requests for permission to carry out aggressive interrogations were sent by Pappas to Lieutenant General Sanchez, the commander on the ground in Iraq, and some have been leaked to the press.

In one example, Pappas seeks permission to conduct an aggressive interrogation of a Syrian detainee believed to possess information about insurgent safe houses and the smuggling of foreign fighters into Iraq. Pappas requests permission "at a maximum, [to] throw tables, chairs, invade his personal space and yell continuously" at the detainee, while taking "all necessary precautions that all thrown objects are clear of the detainee and will not coerce the detainee in any way."[7] If the detainee "has not broken yet," he is to be moved to the "segregation phase," during which he will be transported to another location and strip-searched in the presence of barking military dogs. This is to occur after an empty sandbag has been placed over the detainee's head "for the safety of himself" and others. Finally, he is to be placed on a seventy-two-hour "adjusted sleep schedule," during which he will be interrogated continuously using such approaches as "fear up harsh" and "pride and ego down," as well as silence, loud music, and stress positions. Other interrogation plans may have been even more aggressive. Official and unofficial reports indicate that detainees have been subjected to various other forms of pressure, rising to the level of coercion, including exposure to temperature extremes, a tactic sometimes used in combination with prolonged isolation.[8]

At this time, there is no conclusive evidence that a physician or psychiatrist approved the aggressive interrogation tactics described in this plan. We know, however, that this approval was central to the system envisaged by Miller and described by Pappas. That system also looked to them to confirm that detainees would not suffer long-term harm. However, Miller's description of the strategic role of Biscuits makes clear that medical personnel were not simply gatekeepers. There is evidence, for example, that they reviewed detainee medical records to find "weak spots"—such as a severe phobia of the dark—and that they advised interrogators to exploit detainees' fears and induce extreme stress in order to create opportunities to reshape their behavior.[9] Some detainees have also claimed that they were forcibly drugged as part of the interrogation process.[10] Until military doctors speak out about their experiences or more documents become public, questions about the nature of their participation will remain. But we can and should begin addressing the legal and ethical issues now.

The Legal Boundaries

The question of torture has received considerable attention from both public officials and academic commentators since the 9/11 attacks, most infamously in the now-discredited August 2002 memorandum from then Assistant Attorney General Jay Bybee to then White House Counsel Alberto Gonzalez. That memo narrowly defined physical torture as requiring pain "equivalent in intensity to the pain accompanying serious physical injury, such as organ failure, the permanent impairment of a significant bodily function, or even death."[11] The prohibition of torture is of fundamental importance and, as Jeremy Waldron has recently argued, archetypal of the line that separates law from brutality.[12] Although the current academic debate often ignores this, the international ban is absolute.[13] Unlike other "qualified" human rights, it may not be overridden in the pursuit of social or military objectives. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (known as "the Torture Convention") also makes clear that "[n]o exceptional circumstances . . . may be invoked as a justification of torture," a point the United States did not dispute when it ratified the Convention.[14] However, torture is not the only form of conduct prohibited. International human rights law—which applies in war as well as times of peace[15]—also prohibits cruel, inhuman, and degrading treatment or punishment[16] and requires the humane treatment of detainees.[17] Interrogation techniques employed in the "war on terror," such as stress positions, hooding, sleep deprivation, and subjecting detainees to noise, can constitute inhuman and degrading treatment, particularly when used in combination.[18]

Where the Geneva Conventions apply—and the Bush administration has accepted that they apply in Iraq—they provide further protections for detainees. In addition to prohibition of physical and mental torture and "any other form of coercion," prisoners of war must be protected against "acts of violence or intimidation and against insults and public curiosity." If they refuse to answer questions during interrogation, they "may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind."[19] Similar protections are also provided for civilian detainees.[20] Depriving a prisoner of war of a meal when he refuses to answer a question would be a "simple" breach of the Geneva Conventions. But if a detainee is exposed to a regime of stressors that constitutes inhuman treatment or deliberately causes great suffering, then—even though the treatment does not rise to the level of torture—a grave breach of the Geneva Conventions will have been committed.[21] Grave breaches are also called "war crimes."[22]

The implications for a physician or psychiatrist who approves or monitors an aggressive interrogation are staggeringly clear. He cannot focus solely on medical criteria. Legal

thresholds—most notably those in the Geneva Conventions—may be passed long before the long-term physical or mental health of the detainee is implicated. If doctors ignore those thresholds, they will find themselves in violation of the Geneva Conventions, and in some cases they will be complicit in the commission of war crimes. Doctors who participate in interrogation should therefore be as well-schooled in the legal standards applicable to interrogation tactics as they are in any medical standards.[23]

An Ethical Compass

Law is not the only constraint on physician participation in interrogation. Professional ethical standards also speak to this matter. Not surprisingly, the principles of medical ethics adopted by the U.N. General Assembly for the protection of detainees take the view that physician participation or complicity in torture or cruel, inhuman, or degrading treatment is a "gross contravention of medical ethics."[24] The principles also hold that medical ethics are contravened when physicians use their knowledge and skills to assist in interrogation—or to certify detainees' fitness for interrogation—when it may adversely affect a detainee's physical or mental health or condition and it is "not in accordance with the relevant international instruments."[25] But the principles do not provide thorough or clear ethical guidance for physicians participating in an interrogation conducted in compliance with international human rights law and the laws of war. It is here that more work is urgently needed.

At least one academic has argued that physicians should not be permitted to rely on their professional obligations to escape the duties of citizenship, and that those duties may require physicians to participate in aggressive interrogations—even those that violate international law.[26] And a senior Department of Defense official has contended that physicians who participate in interrogation are not acting as physicians, and that medical ethics simply do not apply.[27] These claims deprive physicians of a vital ethical compass to guide them through the most dangerous terrain. Moreover, they are inconsistent with the underlying assumption of the U.N. Principles—namely, that when physicians exercise medical knowledge and skill, they should be subject to the constraints of medical ethics. A more candid approach would be to acknowledge that physicians are being asked to participate in interrogation because they are physicians, and that this may be due to their social authority as much as—if not more than—their technical skill. The important question then is: are these interrogation practices activities in which physicians should be involved?

Addressing this question requires us all to face up to the tension between the medical profession's social and therapeutic purposes. Physicians should not be left entirely on their own to chart a course between these competing concerns. A map should be drawn up with input from military and civilian personnel, physicians, lawyers, ethicists, and laity. However, there are some lessons that can be drawn from international human rights jurisprudence and its experience over the last half century in mediating between human rights and competing social concerns. Human rights law seeks to maintain the primacy of human rights while permitting the state to interfere with them in compelling cases. Although some human rights are absolute, as is the case with the prohibition on torture, others—such as the right to privacy—are qualified. Interference with the latter may be justified if, and only if, it responds to a pressing social or public need, pursues a legitimate aim, is proportionate with the achievement of that aim, and uses the least restrictive means possible.[28] The burden is on those seeking to justify the interference.

There is evidence that medical personnel at Abu Ghraib reviewed detainee medical records to find "weak spots," and that they advised interrogators to exploit detainees' fears.

An ethical template for physicians should address similar cumulative concerns. Do the nontherapeutic practices—in this case, advice on the design and implementation of interrogation plans—respond to a pressing social or public need? Are they designed to achieve a legitimate aim? Are they proportionate with that aim? Is the practice tailored so that the incompatibility with therapeutic medicine is minimized? Can the practice be safely and effectively performed by someone other than a physician? These questions may not always be easily answered, but those seeking to justify physician participation in nontherapeutic practices should bear the burden of proof.

Pragmatic Pitfalls

Those who advocate physician participation in interrogation must also anticipate the pragmatic hazards. One argument often made in support of involving physicians in interrogation is that their presence may prevent more aggressive conduct by interrogators. Without the physician, supposedly, even greater abuses would occur. But the implications of this argument are usually ignored. The physician who stands by while an interrogator commits war crimes would have no de-

fense simply on the grounds that the abuse might have been even more egregious in his absence.

The argument also ignores the social or institutional pressure on the physician not to intervene in an abusive interrogation. This may arise from public statements by military or civilian leadership (such as Miller's description of the Guantanamo detainees as "the worst of the worst"[29]), from active discouragement by interrogators and other military personnel, from a physician's reluctance to confront those on whom his own safety depends, or from a desire to save interventions for the most egregious cases so as not to exhaust the ability to exercise influence. All these factors are likely to have a chilling effect on physician intervention. Moreover, physicians who fail to intervene may unwittingly encourage interrogators to go further. Like the child who is not disciplined by his parents, an interrogator may become more and more aggressive in order to determine the boundaries of his conduct.

These are empirical claims, open to refutation. There is good reason to suspect that such escalation occurred in Iraq, however, and that we always risk such escalation when we use physicians as gatekeepers of abusive conduct.[30]

We must be honest about what it is that we expect from physicians in interrogation and why we are asking them to participate. It is clear that not all medical personnel attached to Biscuits were selected for their technical skills. The level of training of most Biscuit medical personnel is not publicly known, but the forensic psychiatrist dispatched to military intelligence at Abu Ghraib in late 2003 did not appear to have any special training that would have prepared him for his new assignment.[31] Physicians should not be used simply to confer an air of legitimacy or the imprimatur of decency on aggressive interrogations.

If we are truly concerned about protecting the health of detainees during interrogation, it would be better not to embark on aggressive interrogation at all. The U.S. Army's own field manual states that the use of coercion (including intimidation, threats, and insults) is "not necessary to gain the cooperation of sources for interrogation . . ., is a poor technique that yields unreliable results, may damage subsequent collection efforts, and can induce the source to say what he thinks the interrogator wants to hear."[32] The FBI claims to have adopted more benign "rapport-building" techniques in its interrogations abroad, and its employees have been critical of the more aggressive approaches used by the Department of Defense.[33] A number of experienced interrogators and psychologists—including the chief psychologist of the Naval Criminal Investigation Service—have also expressed the view that rapport-building is the most effective approach for producing reliable information.[34] They doubt the efficacy of aggressive tactics on suspected Al Qaeda operatives, even in "ticking time bomb" scenarios.[35] For obvious legal and ethical reasons, no experiment could legitimately be conducted to disprove their thesis.

Although noncoercive interrogation would not ordinarily implicate a detainee's health, there is a case for having an independent physician on standby. But this individual should be truly an advocate for the detainee—like a suspect's lawyer present during police questioning. Such a physician should be unaccountable to military intelligence and insulated as much as possible from the institutional pressures of the interrogation environment and the military mission.[36] His presence should reflect and embody the aspiration, voiced by Rafael Campo, that "[e]ven the most despised and isolated of patients has someone to whom he can turn, one who truly does have the power to heal."[37]

The physician who stands by while an interrogator commits war crimes would have no defense on grounds the abuse might have been more egregious in his absence.

Those who wish to endorse the active participation of physicians in the design and implementation of interrogation plans must be prepared to embrace the interrogation ethos and its institutional sequelae, not just the practice. They must be ready to teach "interrogation medicine" and "interrogation psychiatry" courses, which would presumably explore the physiological and psychological responses to interrogation stressors. They must also be ready to admit specialization in these fields and to accept the establishment of professional societies for those who practice in them. And they must endure all the consequences this may have for physicians and medicine in civilian life.

Here, we would do well to remember Galgut's army doctor. In the highly pressured interrogation environment, he failed to intervene. This became his "grand defining moment," and he soon learned to accept failure as an "inevitable part of [his] position." The reader finds him, decades later, in a rundown and forgotten hospital in a rural backwater in a post-Apartheid South Africa. He has few patients to treat and is reluctant to do anything that would alter this state of affairs. He is a physician who has lost his way and, with it, the will to heal. By setting physicians up to fail in an aggressive interrogation environment, we risk destroying them not just as healers, but as human beings. We also undermine trust in physicians generally and in the institutions to which they belong.

In a "war on terror" that has no foreseeable end, these are surely costs we cannot afford to pay.[38]

Acknowledgment

The author is grateful to the Greenwall Foundation for fellowship funding that helped make this work possible. He would also like to thank Rebecca Kukla for recommending "The Good Doctor" and M. Gregg Bloche, Jonathan Moreno, and Lisa Sternlieb for comments on earlier drafts.

1. See R.J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 1986); M.G. Bloche, "Uruguay's Military Physicians: Cogs in a System of State Terror," *Journal of the American Medical Association* 255 (1986): 2788-93; and C. Reis et al., "Physician Participation in Human Rights Abuses in Southern Iraq," *Journal of the American Medical Association* 291 (2004): 1480-86.

2. M.G. Bloche and J.H. Marks, "When Doctors Go to War," *New England Journal of Medicine* 352 (2005): 3-6; S.H. Miles, "Abu Ghraib: Its Legacy for Military Medicine," *Lancet* 364 (2004): 725-29. On physician failure to report abuses, see R.J. Lifton, "Doctors and Torture," *New England Journal of Medicine* 351 (2004): 415-16.

3. Bloche and Marks, "When Doctors Go To War."

4. Ibid.

5. A. Zagorin and M. Duffy, "Inside the Interrogation of Detainee 063," *Time*, June 20, 2005 (containing excerpts from a Guantanamo Bay interrogation log). See also Document DOD-DOACID000558, http://action.aclu.org/site/PageServer?pagename=torturefoia.

6. Testimony of Col. Thomas M. Pappas to Taguba Inquiry (February 2004), available at http://www.aclu.org/torturefoia/released/a46.pdf.

7. Col. Thomas M. Pappas, memorandum to Lt. Gen Ricardo S. Sanchez: Request for Exception to CJTF-7 Interrogation and Counter Resistance Policy, http://www.publicintegrity.org/docs/AbuGhraib/Abu7.pdf.

8. Tactics such as mock executions and sexual humiliation were also used but are unlikely to have been the subject of formal requests. For discussion of techniques used, see the Taguba, Fay/Jones, and Schlesinger Reports collected in K.J. Greenberg and J.L. Dratel, *The Torture Papers: The Road to Abu Ghraib* (New York: Cambridge University Press, 2005) and Physicians for Human Rights, *Break Them Down: Systematic Use of Psychological Torture by US Forces* (Washington, D.C.: Physicians for Human Rights, 2005).

9. N. Lewis, "Interrogators Cite Doctors' Aid at Guantanamo Prison Camp," *New York Times*, June 24, 2005. See also M.G. Bloche and J.H. Marks, "Doctors and Interrogators at Guantanamo Bay," *New England Journal of Medicine* 353 (2005): 6-8.

10. P. Dodds, "Released Gitmo Prisoners Sue for Damages," *Army Times*, October 27, 2004. Compare reports of the CIA's use of drugs in interrogation: M. Bowden, "The Dark Art of Interrogation," *Atlantic Monthly*, October 2003, 51-76.

11. Memorandum for Alberto R. Gonzales from Jay S. Bybee, Re: Standard of Conduct for Interrogation under 18 USC 2340-2340A, collected in Greenberg and Dratel, eds., *The Torture Papers*. The memorandum was withdrawn in June 2004 and replaced by Memorandum for James B. Comey from Daniel Levin, Re: Legal Standards Applicable under 18 USC 2340-2340A, December 30, 2004, available from www.usdoj.gov/olc/dagmemo.pdf. For academic discussion of torture, see S. Levinson, ed., *Torture: A Collection* (New York: Oxford University Press, 2004).

12. See J. Waldron, "Torture and Positive Law: Jurisprudence for the White House," http://www.columbia.edu/cu/law/fed-soc/otherfiles/waldron.pdf.

13. See the International Covenant on Civil and Political Rights (1966) 999 U.N.T.S. 171 (ICCPR) and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) 1465 U.N.T.S. 85.

14. Article 2(2) of CAT. For the text of the U.S. ratification, see 100 Cong. Rec. 36194 (1990). See also Article 4(2) of the ICCPR.

15. International Court of Justice, Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion of July 8, 1996, paragraph 25.

16. See Article 7 of the ICCPR. States are also required to review their interrogation policies to ensure that cruel, inhuman, or degrading treatment does not occur (see Articles 11 and 16 of the Torture Convention).

17. Article 10 of the ICCPR. See also "Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment," UNGAOR 43/173 (December 9, 1988).

18. See *Ireland v. U.K.* (1978) 2 E.H.R.R. 25.

19. Third Geneva Convention Relative to the Treatment of Prisoners of War (1949) 75 U.N.T.S. 135. See articles 13 and 17.

20. Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War (1949) 75 U.N.T.S. 287. See articles 27, 31, and 32.

21. Article 130 of the Third Geneva Convention and Article 147 of the Fourth Geneva Convention.

22. 18 U.S.C. 2441.

23. The focus of the analysis here is on international legal standards. For the applicability of these norms, see P. Sands, *Lawless World: America and the Making and Breaking of Global Rules* (New York: Viking, 2005) 143-73, 204-22.

24. U.N. Principles Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UNGAOR 37/194 (1982), Principle 2.

25. Ibid., Principle 4.

26. M.L. Gross, "Doctors in the Decent Society: Torture, Ill-Treatment and the Civic Duty," *Bioethics* 18, no. 2 (2004): 181-203. In Gross's "inverted world," international law is willfully disregarded and "those upholding patient rights [in times of war] generally bear the burden of proof": see M.L. Gross, "Bioethics and Armed Conflict: Mapping the Moral Dimensions of Medicine and War," *Hastings Center Report* 34, no. 6 (2004): 22-30.

27. Bloche and Marks, "When Doctors Go To War."

28. See United Nations, Economic and Social Council, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities, Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, Annex, U.N. Doc E/CN.4/1984/4 (1984).

29. E. Saar and V. Novak, *Inside the Wire: A Military Intelligence Soldier's Eyewitness Account of Life at Guantanamo* (New York: Penguin, 2005), 193.

30. See also M.G. Bloche, "Caretakers and Collaborators," *Cambridge Quarterly of Healthcare Ethics* 10 (2001): 275-84.

31. Bloche and Marks, "Doctor's Orders: Spill Your Guts," *Los Angeles Times*, January 9, 2005.

32. Department of the Army, Field Manual 34-52: Intelligence Interrogation (1992).

33. See J. Mayer, "The Experiment," *New Yorker*, July 11-18, 2005, drawing on email correspondence from FBI agents at http://action.aclu.org/site/PageServer?pagename=torturefoia.

34. See, for example, S. Budiansky, "Truth Extraction," *Atlantic Monthly*, June 2005, 32-35; Mayer, "The Experiment."

35. M.G. Gelles et al., "An Approach to Interrogating Subjects of Al Qa'ida-related Investigations" in *Investigative Interviewing*, ed. T. Williamson (Cullompton, U.K.: Willan Publishing, forthcoming).

36. The treaty body of the ICCPR, the Human Rights Committee, has expressed the view that suspects should be examined by an independent doctor after each period of questioning. See Concluding Observations of the Human Rights Committee, Switzerland, U.N. Doc. CCPR/C/79/Add.70 (1996) at paragraph 24.

37. R. Campo, "Like a Prayer," in *The Poetry of Healing* (New York: W.W. Norton, 1997).

38. As this issue was going to press, the Office of the Army Surgeon General released—after a delay of several months—a report on detainee medical operations. Although it found "no indication that [Biscuit] personnel participated in abusive interrogation practices," this was not a formal investigation, and no inquiry was made into the specific advice given by Biscuit personnel to interrogators. The author of the report, Maj. Gen. Martinez-Lopez, recommended that "[p]hysicians/psychiatrists should not be used in a [Biscuit] role." However, this recommendation was rejected by the Surgeon General. The report is available at http://www.armymedicine.army.mil/news/detmedopsrprt/detmedopsrpt.pdf, and the transcript of the Surgeon General's press briefing is at http://www.pentagon.gov/transcripts/2005/tr20050707-3301.html.