Looking Back, Thinking Ahead:

The Complicity of Health Professionals in Detainee Abuse

Jonathan H. Marks

"If there were another terror attack in the United States tomorrow, would we make the same mistakes all over again?" This is the question I often ask myself when I review the Bush Administration's domestic and foreign policy in the global war on terror. A new administration brings with it the prospect of new policies, but it would be naïve to assume that we need no longer be concerned about the potential for repressive responses to the threat of international terrorism. While that threat continues (or is perceived to continue), the risk that we will take repressive measures in response remains. I am, of course, not the first to lament our failure to learn from history. The late U.S. Supreme Court justice William Brennan observed toward the end of the Cold War that "[a]fter each perceived security crisis ended, the United States has remorsefully realized the abrogation of civil liberties were unnecessary. But it has proven unable to prevent itself from repeating the error when the next crisis came along."[1] Brennan's observation is as depressing as it descriptively accurate. However, my purpose here is *both* to recognize the powerful constellation of factors that seem to lead (almost ineluctably) to fundamental errors in national security policy in the wake of terror *and* to explore how we can equip ourselves so we have the best chance of avoiding them.

There are many mistakes whose recurrence I would wish to avoid, but at the top of my list is the deployment of aggressive interrogation strategies—tactics that were deployed not on an ad hoc basis, but as the result of policy decisions at the highest levels.[2] These decisions were

[1] William J. Brennan, Jr., "The Quest to Develop a Jurisprudence of Civil Liberties in Times of Security Crises," *Isr. Y.B. Hum. Rts*. 18 (1988): 11.

[2] *See, for example*, Philippe Sands, *The Torture Team* (Palgrave Macmillan, 2008); Jane Mayer, *The Dark Side* (Doubleday, 2008).

mistaken for two reasons. First and foremost, as I have argued at some length elsewhere, these tactics violate fundamental norms of international human rights law and the laws of war.[3] A counterterrorism policy endorsing aggressive interrogations is, for that reason alone, simply wrong. To be clear, my legal contention is, by itself, a sufficient argument against adopting such a policy. However, since illegality has not been decisive in the past to deter some advocates of aggressive interrogation strategies, it is important to note the powerful second argument for labeling these strategies as mistaken. For this argument, I rely not on my own expertise, but on the expertise of others: experienced interrogators and psychologists. The experts have made clear time and again that neither torture nor aggressive interrogation is the best way of producing reliable intelligence.[4] Rather, an approach that builds rapport is much more effective.[5] Even if—contrary to the expert view—torture and aggressive interrogation strategies in violation of fundamental legal norms were effective, they would (of course) still be wrong as a matter of law. But we would do well to remember that the adoption of such strategies is mistaken for two reasons: one legal, the other pragmatic.

Ethical constraints should have provided a third obstacle to the systemic deployment of these strategies, since they could not have been formally adopted without the help of a variety of professionals—in particular, the lawyers who drafted the so-called "torture memos," the psychologists who helped devise the aggressive interrogation strategies, and the physicians who concealed or failed to report evidence of abuse. The complicity of these professionals and the ethics of their involvement have been widely discussed.[6] The involvement of lawyers and health professionals is a particularly powerful combination—providing, respectively, an imprimatur of legality and a semblance of decency to interrogation strategies that were neither legal nor decent. In keeping with the scope of the book, this chapter will focus on health professionals who were complicit in detainee

---

[3] Jonathan H. Marks, "Doctors as Pawns? Law and Medical Ethics at Guantánamo Bay," *Seton Hall Law Rev.* 37 (2007): 711-731.

[4] *See, e.g.,* "'Torture is for Amateurs': A Meeting of Psychologists and Military Interrogators," *Peace and Conflict: Journal of Peace Psychology* 13 (2007); Michael Gelles et al, "Al-Qaeda-Related Subjects: A Law Enforcement Perspective," in *Investigative Interviewing: Rights, Research, Regulation* (T. Williamson, ed., 2005), 23-41. See also Kleinman, this volume.

[5] *Ibid.*

[6] *See* Steve Miles, *Oath Betrayed: Torture, Medical Complicity and The War on Terror* (Random House, 2007); David Luban, *Legal Ethics and Human Dignity* (Cambridge University Press, 2007) (in particular, Chapter 5 on the "torture lawyers of Washington").

abuse. I will not describe the involvement of health professionals in detail, but their roles have included being "grand architects" of the new aggressive interrogation strategies in the war on terror, "behavioral science consultants" who advised on the design and implementation of individual interrogation plans that employed aggressive tactics, and suppressors of evidence of abuse (by deliberate concealment or failure to report).[7]

In this chapter, the term "health professionals" should be construed broadly. It should be taken to include not only physicians (whether generalists, psychiatrists, or other specialists) and psychologists, but also physician assistants, mental health technicians, nurses, and medics with various degrees of training. There are two reasons for this. First, there is indisputable evidence of the involvement of some of these other health professionals in the interrogation mission, in particular, mental health technicians.[8] Second, as professional organizations such as the American Medical Association and American Psychiatric Association have tightened their ethics codes, there appears to have been a shift away from deploying physicians as adjuncts to the interrogation mission (although, contrary to the understanding that those professional associations had with the Defense Department, there has not yet been a complete abandonment of this practice).[9] For these reasons, measures intended to prevent the complicity of health professionals in detainee abuse must address all potential varieties of health personnel.

We must also recognize that health professionals do not operate in isolation. Lawyers and ethicists tend to focus on the legal and ethical responsibilities (and infractions) of individuals. In bioethics, the focus on individual health professionals is sometimes described as "quandary bioethics" or micro-bioethics. But in order to understand how health professionals could have been complicit in detainee abuse, we must broaden our focus from the *micro* level, which focuses on individuals, to *macro* and *mezzo* levels. In

---

[7] *For a more detailed discussion see Miles*, *supra* note 4, at 43–67 (2006); M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go To War," *New Eng. J. Med*. 352 (2005): 3-6; M. Gregg Bloche and Jonathan H. Marks, "Doctors and Interrogators at Guantánamo Bay," *New Eng. J. Med.* 353 (2005): 6-8; Mark Benjamin, "The CIA's Torture Teachers," *Salon.com*, June 21, 2007, *available at* http://www.salon.com/news/feature/2007/06/21/cia_sere/.

[8] Carl Rosenberg, "A Kinder and Gentler Room to Question Subjects?," *Miami Herald,* February 20, 2006, available at http://www.miamiherald.com/1218/story/321069.html.

[9] *See* Marks, "Doctors as Pawns," *supra* note 3; Jonathan H. Marks and M. Gregg Bloche, "The Ethics of Interrogation—The U.S. Military's Ongoing Use of Psychiatrists," *N. Engl. J. Med*. 359 (2008): 1090-1092.

this context, the macro level refers to the broad social, cultural, and political factors that have shaped the United States' responses to terrorism after 9/11 in the war on terror. The mezzo level refers here to organizational and community perspectives and encompasses local situational and systemic factors that can influence behavior. There are a number of intersecting communities that are relevant, among them the communities of health, military, and intelligence professionals. Understanding the incentives for ethical or unethical behavior at the mezzo and macro levels is critical to any comprehensive ethical critique. In addition, ethical critiques of organizations of which health professionals are members or with which they otherwise interact are long overdue.

Although I have expertise in human rights law and bioethics, I am not a psychologist, sociologist, or anthropologist. For this reason, I will simply set out here the skeletal framework of actual and potential incentives for unethical behavior onto which I hope others from those disciplines will provide the flesh. There is a peculiar irony here (and, some might say, a touch of poetic justice): as we look back, psychologists were instrumental in the design of aggressive interrogation strategies; but as we look forward, psychology may help empower us to prevent a recurrence of those aggressive interrogation strategies.

I. Looking Back: Some Retrospective Reflections

Macro Perspectives

I have written elsewhere about the factors that may have operated at a macro level and contributed to the development of aggressive interrogation strategies in the war on terror.[10] I will summarize these factors only briefly here. There is some evidence that our responses to terrorism after 9/11 have been fueled by emotion and that such emotions exacerbated cognitive biases and skewed deliberative processes both within the government and society at large. Those who doubt the role of emotion need only listen to the repeated assertions of George Tenet, former director of the CIA, who has acknowledged that in the aftermath of 9/11 there was "palpable fear"

[10] Jonathan H. Marks, "9/11 + 3/11 + 7/7 = ? What Counts in Counterterrorism?," *Colum. Hum. Rts L. Rev*. 37 (2006): 559.

within government because there was so much they felt they did not know.[11] The effect of fear on policy choices has been demonstrated by a number of psychological studies.[12] In the wake of 9/11, the resulting cognitive biases gave moral salience to a variety of claims that favored aggressive treatment of detainees. Among these were the claims that the detainees at Guantánamo Bay were "the worst of the worst" and that Mohamed al Qahtani, presumably worst of all, was "the 20th hijacker."[13]

At the same time, these biases led many to ignore other considerations—among them that many of the detainees at Guantánamo Bay had been handed over to the Americans by the Northern Alliance in return for the promise of financial rewards "beyond their wildest dreams."[14] Many of these detainees turned out to have no intelligence value whatsoever. However, their failure to provide intelligence was interpreted as a resistance strategy, rather than as a consequence of their innocence or ignorance. Al Qahtani's "20th hijacker" label earned him the dubious privilege of being the first Guantánamo Bay detainee to be subjected to a "special interrogation plan." But the architects of that plan may have suppressed one fact that should have given them pause for thought—the U.S. government also claimed that another prisoner, Zacarias Moussaoui, was the 20th hijacker.[15] As Philip Zimbardo—the principal investigator of the famous Stanford Prison Experiment—recently pointed out, there is a substantial body of empirical evidence that demonstrates the power of labeling, particularly when it is used to dehumanize people who are subjected to punitive conditions.[16]

I will return later to discuss in more detail how labels, in conjunction with cognitive biases, might have affected military personnel in high-pressure interrogation environments. However, the label that Moussaoui and al Qahtani shared is just one example of a *narrative construct* that

---

[11] George Tenet, "Interview with Scott Pelley," *60 Minutes*, April 29, 2007, *available at* http://www.cbsnews.com/stories/2007/04/25/60minutes/main2728375_page3.shtml.

[12] Jennifer S. Lerner et al., "Effects of Fear and Anger on Perceived Risks of Terrorism: A National Field Experiment," *Psychol. Sci.* 14 (2003): 144, 146. On the effects of moral emotions—including moral outrage—see, Sabrina Pagano and Yuen Huo, "The Role of Moral Emotions in Predicting Support for Political Actions in Post-War Iraq," *Political Psychology* 28 (2007). On the impact of "feeling threatened" on policy decisions, see Carol Gordon and Asher Arian, "Threat and Decision Making," *J. Conflict Resolution* 45 (2001): 196-215.

[13] I discuss this further in Jonathan H, Marks, "The Language and Logic of Torture," *Comparative Literature and Culture*, 9 (2007) *available at* http://docs.lib.purdue.edu/clcweb/vol9/iss1/11.

[14] *Ibid.*

[15] *Ibid.*

[16] Philip Zimbardo, *The Lucifer Effect: Understanding How Good People Turn Evil* (2007), 308-310.

fuelled aggressive counterterrorism policies. At the macro level, additional narratives operated—most notably, "ticking bombs" in the shape of Al Qaeda affiliates armed with nuclear devices that could destroy an entire American city.[17] Fear of ticking bombs seemed all the more justified when the Bush Administration sought to build a case for the invasion of Iraq by claiming that Saddam Hussein had *both* weapons of mass destruction and links to Al Qaeda and that we could not "wait for the final proof – the smoking gun – that could come in the form of a mushroom cloud." [18]

The factors described above—our emotional responses, cognitive biases and narrative constructs—coalesced in powerful ways, creating what might be termed an internal "coalition of the willing"—in which broad sections of the public came to support torture as a necessary evil.[19] To understand how this occurred, it is also important to recognize another vital piece of the picture at the macro level which I am inclined to term "the false promise of force."

Faced with threats that were described as exceptional and unparalleled in their magnitude—a claim that was surely suspect, given the potential for what was termed "mutually assured destruction" in the Cold War—we were told that "the gloves" had to "come off."[20] In particular, this meant the use of what were euphemistically called "enhanced interrogation techniques." What was implicitly accepted without critique was that aggressive interrogation strategies would be productive—that is, that they would help make us safer. We were presented with a false trade-off—that the most fundamental rights of detainees (among them, the freedom from torture and from cruel, inhuman, and degrading treatment) had to be sacrificed to guarantee our security.[21] Although the experts have long made clear that the use of force is not a reliable way to extract intelligence,[22] force may have offered some short-term emotional rewards, empowering those who deployed it and

[17] I discuss this further in Marks, "Language and Logic," *supra* note 13.

[18] Office of the Press Secretary of the White House, "President Bush Outlines Iraqi Threat," October 7, 2002, *available at* http://www.whitehouse.gov/news/releases/2002/10/20021007-8.html.

[19] *See, e.g.,* Steven Kull et al., "Americans on Detention, Torture and the War on Terrorism," *Program on International Policy Attitudes / Knowledge Networks,* July 22, 2004, *available at* http://www.pipa.org/OnlineReports/Terrorism/Torture_Jul04/Torture_Jul04_rpt.pdf (accessed December 15, 2008).

[20] Cofer Black, *Congressional Testimony*, September 26, 2002, *available at* http://www.fas.org/irp/congress/2002_hr/092602black.pdf (last accessed, August 23, 2008).

[21] For a powerful critique of the relationship between liberty and security, see Jeremy Waldron, "Security and Liberty: The Image of Balance," *J. Pol. Phil.* 11 (2003): 191, 195.

[22] S. Budiansky, "Truth Extraction," *Atlantic Monthly* (June 2005): 32-35.

providing a release from the grip of fear. The false promise of torture is ordinarily evident to those who are experts, but it is not so obvious to the general public or to young, trainee interrogators whose imaginations have been fueled by Hollywood confections such as *24*—a series the dean of the U.S. Military Academy at West Point has criticized for its "toxic effect," promoting a torture-tolerant culture and undermining the training and performance of U.S. military personnel.[23]

Before discussing the role of military health professionals in more detail, we should also recall the efforts of the Bush Administration to strip away applicable law that might otherwise have served to prevent detainee abuses. These are now well documented—most recently, by international lawyer Philippe Sands in his book *Torture Team,* and by Jane Mayer in her book *The Dark Side*.[24] I have described the administration's efforts elsewhere as a campaign of *legal exceptionalism* that sought to dispense with or render nugatory domestic and international legal norms that should have protected detainees from abuse.[25] Documents recently obtained by the American Civil Liberties Union in response to hotly-contested Freedom of Information Act requests make clear that the Office of Legal Counsel at the Department of Justice even advised the CIA that waterboarding did not constitute torture (at least, for the purpose of the Torture Statute).[26] The purported elimination of legal constraints—coupled with the labeling and dehumanizing of detainees and the incredible pressure to obtain actionable intelligence—created a potent cocktail that greatly increased the likelihood that abuses would take place and that deaths in custody would result.

Mezzo Perspectives

To understand the systemic and structural factors that may have contributed to health professionals' unethical and illegal behaviors, a number of communities and sub-communities need to be explored. In essence, three clusters of communities should be mentioned. The first cluster is made of national security and military communities involved in counterterrorism.

---

[23] Jane Mayer, "Whatever It Takes: The Politics of the Man Behind 24," *New Yorker* (February 19-26, 2007): 66-82.

[24] *See* Sands, *supra* note 2.

[25] *See* Marks, "What Counts," *supra* note 10.

[26] *See* ACLU Safe and Free at Home, "Legal Memo Department of Justice," *available at* http://www.aclu.org/pdfs/safefree/cia_3685_001.pdf (last accessed December 15, 2008).

I use the term "cluster of communities" because distinctions can and should be drawn between, for example, the Defense Department, the CIA, the NSA, and the FBI—as well as between different agencies within the Defense Department and between the civilian and military leadership in the Department. These distinctions are substantiated by increasing evidence of disagreements between these various communities – most famously, the FBI's repudiation of the aggressive approach to interrogation favored by the civilian leadership in the Defense Department. The second cluster is made of health professionals and their professional organizations. Again, distinctions can be drawn between physicians, psychologists, nurses, and mental health technicians—to name just a few – as well as between professionals, their organizations and those organizations' leadership. The third cluster is a smaller one that reflects the interwoven nature of the first two clusters. It is made of the myriad health professionals who contract with, consult for, or are employed by defense and national security agencies. At its core are the psychologists who have played a significant role in formulating the new aggressive interrogation tactics and were also – despite the clear conflict of interest — key architects of the American Psychological Association's policy on interrogation (in particular, the 2005 Report of its Presidential Task Force on Psychological Ethics and National Security), formulated in the wake of revelations of detainee abuses at Abu Ghraib and Guantánamo Bay.[27]

Looking first at military communities, there are a number of key organizational and structural factors that Jean Maria Arrigo and Ray Bennett (a psychologist and retired military interrogator, respectively) have identified.[28] First, experienced interrogators did not occupy sufficiently senior positions in the military hierarchy, so they could not bring their expertise to bear on the development of the Army's new aggressive interrogation strategies. If they had, they would have challenged the claim that so-called "enhanced interrogation techniques" were really enhanced (as several of them have recently done publicly).[29] Second, since the late 1980s, the Department of Defense had given greater priority to imagery and signals intelligence than to

[27] For a discussion of the 2005 PENS Task Force Report and its sequelae, see, for example, Amy Goodman and David Goodman, "Psychologists in Denial," in *Standing Up to the Madness: Ordinary Heroes in Extraordinary Times*, eds. Amy Goodman and David Goodman (Hyperion, 2007).

[28] Jean Maria Arrigo and Ray Bennett, "Organizational Supports for Abusive Interrogations in the 'War on Terror,'" *Peace and Conflict: Journal of Peace Psychology* 13 (2007): 411-421; *see also* Arrigo and Brewer, this volume.

[29] *See, e.g.,* "Torture is for Amateurs," *supra* note 4.

human intelligence. As a result, after 9/11 (and, in particular, following the invasion of Iraq in 2003), experienced interrogators were in extremely short supply. According to Arrigo and Bennett, this resulted in lower standards for the selection, training and placement of new military interrogators. (The Army then asked nineteen-year-old novices to interrogate detainees who did not respond to direct questioning—a task that, in previous conflicts, would have been reserved for only the most experienced interrogators.)

This was the detention and interrogation environment into which health professionals were introduced. A number of psychologists and psychiatrists became part of the intelligence-gathering mission, whether or not they desired to do so, whether or not they had any experience of interrogation, and whether or not they had any professional skills that they could or should have brought to the interrogation mission.[30] Their ability to act ethically may also have been further impaired by a number of other factors. First, military health professionals often have financial constraints. Many entered the health professions via the military because they had no other way to pay for their medical education.[31] Speaking out against detainee abuses could entail more than social costs for them—there might be serious financial implications. In the event that these health professionals were forced to leave the military, they would likely face the prospect of having to repay the military for the cost of their professional education.[32] Second, even when health professionals do not have such concerns in mind, they might nonetheless perceive that they have a limited and easily exhaustible amount of *intervention capital*. Believing that they can only intervene or speak out so many times before being dismissed as unpatriotic or accused of "crying wolf,"[33] they might reasonably fear that either of these characterizations could have an adverse impact on their future assignments or deployments. For that reason, they may be inclined to save their objections for the most egregious cases. Failure to speak out in other cases might then be interpreted as acquiescence in the use of aggressive tactics.

In addition to these two *inhibitive* factors that may operate to make health professionals reluctant to "do the right thing," a third factor has the potential to lead to the more enthusiastic embrace of unethical behaviors.

---

[30] *See* Bloche and Marks, "Doctors and Interrogators," *supra* note 7.
[31] *See* Marks, "Doctors as Pawns?," *supra* note 3, at 729.
[32] *Ibid.*
[33] I discuss this further in Jonathan H. Marks, "Doctors of Interrogation," *Hastings Center Report* 35 (2005): 17-12.

As more than one experienced interrogator has explained to me, some health professionals in the interrogation environment suffer from *wannabe-ism*. Military health professionals are often perceived by their non-medical colleagues as "not real soldiers." Doctors in particular ordinarily wear a caduceus (the staff entwined by two snakes and topped with wings) that marks them as different from others; when they act as health care providers, they are also non-combatants for the purpose of the Geneva Conventions with the concomitant privileges and protections afforded to them by the laws of war.[34] When health professionals become attached to the intelligence mission as behavioral science consultants, they thereby surrender their non-combatant status under international law. However, their new assignment provides compensation for the loss of this *legally* privileged status: the acquisition of *socially* privileged status by reason of their association with and potential acceptance into the innermost sanctum of the intelligence community. This prospect may well inculcate in behavioral science consultants a desire to do more than simply provide assistance to intelligence operatives—they want to become "one of them." More than sixty years ago, C. S. Lewis identified the hazards created by the unbridled desire to gain admission to a privileged inner circle or "ring," when he observed that "[o]f all the passions, the passion for the Inner Ring is most skillful in making a man who is not yet a very bad man do very bad things."[35]

These factors create systemic problems and the potential for abuse of the kind that occurred at Abu Ghraib and elsewhere. Different theorists have presented the problem in slightly different ways. For Robert Jay Lifton, the concept of the "atrocity-producing situation"—one that he fashioned to explain the conduct of Nazi doctors—had explanatory power in relation to detainee abuses in the war on terror.[36] Another concept that has been invoked is "behavioral drift," that is, the slide into unprofessional and ultimately illegal behaviors.[37] This term has been used defensively by psychologists seeking

---

[34] *First Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, August 12, 1949, article 24.

[35] C. S. Lewis, *The Inner Ring* (1944), *available at* http://www.lewissociety.org/innerring.php (last accessed August 1, 2008). The author is extremely grateful to David Luban for bringing this essay to his attention.

[36] Robert Jay Lifton, "Doctors and Torture," *New Eng. J. Med.* 351 (2004): 415 – 416.

[37] *See* Gerald P. Koocher, "Varied and Valued Roles," *Monitor on Psychol.* (July-Aug. 2006): 5; Stephen Behnke, "Ethics and Interrogations: Comparing and Contrasting the American Psychological, American Medical and American Psychiatric Association Positions," *Monitor on Psychol.* (July-Aug. 2006): 66.

to describe the behaviors of wayward interrogators and the potential role that psychologists might play in detecting and counteracting this tendency.[38] However, psychologists who are assigned to advise interrogators may equally be subject to behavioral drift, and there is considerable evidence that this has already happened. For example, the interrogation log of Mohamed al Qahtani records the intermittent presence of a psychologist during his life-threatening and profoundly humiliating interrogation, which was conducted for forty-eight days over a fifty-four day period for eighteen to twenty hours a day.[39] (It is likely that this psychologist—who chaired a behavioral science consultation team at Guantánamo Bay—also advised on the content of al Qahtani's aggressive interrogation plan, and documents recently made public suggest he may have had a larger role as one of the architects of the Administration's new interrogation strategy.[40]) Another concept that might be applied here is "moral seduction." Forged in the context of conflicts of interest, this is defined as follows: "Putting the most Machiavellian fringes of professional communities aside … the majority of professionals are unaware of the gradual accumulation of pressures on them to slant their conclusions."[41] Like behavioral drift, this concept recognizes the often gradual nature of the process. The language of seduction, however, also serves to emphasize that the process does not take place in a vacuum—other people and the systems they put in place may advance or hinder the process.

As I have discussed in greater detail elsewhere, there were, of course, numerous ethical (as well as legal) norms that should have prevented health professionals from participating in these aggressive interrogations.[42] Moreover, in 2006, the American Medical Association, the American Psychiatric Association, and the World Medical Association all amended their policies to make clear that physicians should not advise

---

[38] *Ibid.*

[39] Bloche and Marks, "Doctors and Interrogators," *supra* note 7. For a book-length discussion of the evolution of this aggressive interrogation plan, see Sands, *supra* note 2.

[40] This psychologist participated in a "Counter Resistance Strategy Meeting" held on October 2, 2002. *See* "Origins of Aggressive Interrogation Techniques: Committee Inquiry into Treatment of Detainees: Index of Documents," Released by the Office of Senator Carl Levin, 14-17, *available at* http://levin.senate.gov/newsroom/supporting/2008/Documents.SASC.061708.pdf (last accessed December 15, 2008).

[41] Don Moore et al., "Conflicts of Interest and the Case of Auditor Independence: Moral Seduction and Strategic Issue Cycling," *Academy of Management Review* 31 (2006): 1–20.

[42] *See* Steve Miles, "Medical Ethics and the Interrogation of Guantánamo 063," *American Journal of Bioethics* 7 (2007): 1–7; Marks, "Doctors as Pawns," *supra* note 3.

on or participate in individual interrogations, whether those interrogations are legal or not.[43] However, one community of health professionals – the leadership in the American Psychological Association – was, for several years, reluctant to prohibit its members' participation in interrogations at Guantánamo Bay or elsewhere in the war on terror. Some argued that this was because several psychologists who crafted or implemented the Bush Administration's new interrogation policy were also shaping the policy of their professional organization.[44] For others, the failure of the American Psychological Association to take as firm a stand as the medical professional associations have taken reflects the bifurcated nature of the profession. When I lecture on these issues, clinical psychologists usually tell me that they wish to be held to the same ethical standards (and to have the same social status) as physicians. But non-clinical psychologists often believe that those standards are inappropriate for them.[45] I will return to the role of professional associations in addressing these kinds of issues toward the end of this chapter.

Individual Perspectives

Both the macro and mezzo perspectives described above help to explain individual behaviors and, in particular, to set the scene for a number of cognitive errors. In his recent book, *How Doctors Think*, Jerome Groopman drew together many strands from recent research in cognitive psychology to explain why doctors make mistakes. Many of the cognitive pitfalls he identifies might equally explain the behaviors of those attached to interrogation units—in particular, young, novice interrogators and health professionals with no experience of interrogation. For example, *fundamental attribution error* results from our tendency to attribute behaviors to disposition or personality, rather than to situational factors.[46] In a medical context, it might cause a physician to attribute the symptoms of a poorly-dressed, unshaven man in the emergency room with alcohol

[43] *See* Marks, "Doctors as Pawns," *supra* note 3.

[44] *See* Goodman, *supra* note 27.

[45] *For a brief discussion of this issue, see, for example,* Stanley Fish, "Psychology and Torture," *New York Times Blog,* November 9, 2008, *available at* http://fish.blogs.nytimes.com/2008/11/09/psychology-and-torture/ (last accessed November 10, 2008). The author is grateful to Don Thompson for drawing this blog entry to his attention.

[46] Jerome Groopman, *How Doctors Think* (Mariner Books, 2007), 44 – 46.

on his breath to alcoholic cirrhosis, and to miss a chronic condition that would be potentially very serious if left untreated.[47] At Guantánamo Bay, when many detainees failed to provide any intelligence, this appears to have been attributed to their grim determination as hardened terrorists not to reveal any information. This attribution was facilitated by the claims made by administration officials that the detainees at Guantánamo Bay were "the worst of the worst."[48] An alternative explanation subsequently endorsed by numerous intelligence experts, however, is that many of the detainees had no involvement in terrorist activities and had no information to impart.[49]

A number of other biases may also have been playing out—among them, *confirmation bias*, which leads people to focus on information that appears to confirm their initial judgment and to ignore information that contradicts it.[50] Faced with terror suspects, this bias might draw intelligence personnel to conclude that detainees were not speaking because they were hardened terrorists and to ignore or downplay other exculpatory information. In a medical context, *confirmation bias* can also lead to *diagnosis momentum*.[51] Once a diagnosis is attached to a patient, despite incomplete or inconsistent evidence, the physician may be reluctant to revisit the diagnosis. The doctor's colleagues may similarly be reluctant to do so, particularly if they are subordinates. As a result, one ineffective therapy may be deployed after another – sometimes for several years. Similarly, the "diagnosis" of a detainee as a terrorist is one that may be difficult for intelligence operatives to revisit, particularly given that military culture emphasizes obedience to authority and can heighten the forces of conformity and compliance that operate within groups. Thus, when one set of aggressive interrogation techniques is unsuccessful, it may be swiftly followed by another. The alternative explanation, that the detainee does not have any intelligence value, will be arrived at with the greatest reluctance.

Commission bias pushes people toward doing something rather than

---

[47] *Ibid.*

[48] Eric Saar and V. Novak. *Inside the Wire: A Military Intelligence Soldier's Eyewitness Account of Life at Guantánamo* (Penguin Press, 2005), 193.

[49] *For a critique of the allegations made against the detainees based solely on the government's documents, see* Mark P. Denbeaux et al., *Second Report on the Guantánamo Detainees: Inter- and Intra-Departmental Disagreements About Who Is Our Enemy* (Seton Hall University, 2006), *available at* http://law.shu.edu/news/second_report_Guantánamo _detainees_3_20_final.pdf.

[50] *See,* e.g. Groopman, *supra* note 46, at 65–66.

[51] *Ibid.* at 128.

nothing.[52] In an interrogation context, a gradual rapport-building approach might feel like "doing nothing", while deploying aggressive interrogation strategies may feel like "doing something." Psychologist Ronnie Janoff-Bulman has also argued that "a crude form of the representativeness heuristic" could explain the use of aggressive interrogation strategies because "people may erroneously assume that information from cruel, bad, harsh enemies can only be produced by similarly cruel, bad, harsh techniques."[53] This assumption would have been reinforced by fictional examples of aggressive interrogations, whether from the television series *24* or elsewhere, which the *availability heuristic* almost certainly brought into play. When we deploy such a heuristic (or mental shortcut), we tend to assess the probability of an event by reference to the ease with which an example comes to mind.[54] Television has provided us with countless examples of "interrogational torture" that produced nuggets of actionable intelligence—enabling our heroes to defuse ticking time bombs at the last moment. Gentler and more prolonged rapport-building interviews do not have the same dramatic impact so they are less appealing to writers of fiction and movie directors – and, consequently, they are less available to us and to inexperienced interrogators.

These cognitive pitfalls can be exacerbated by emotional responses, such as anger and fear. Such emotions may have been acute at both Guantánamo Bay and Abu Ghraib, albeit for slightly different reasons. At Guantánamo Bay, there was a widespread belief (particularly in 2002–2003) that another attack on the U.S. mainland was imminent and that al Qahtani and other so-called "high-value detainees" possessed information that might enable us to prevent such an attack. At Abu Ghraib, mortars were coming over the walls of the prison daily and improvised explosive devices (IEDs) frequently killed or maimed U.S. military personnel. In such circumstances, anger and fear are readily understandable responses. *Affective bias* recognizes the impact that such emotions may have on cognitive processes. Although emotion can play a vital role in shaping our goals and focusing our attention, it can also be a "terrible advisor" (in the words of neuroscientist Antonio

---

[52] *Ibid.* at 169.

[53] Ronnie Janoff-Bulman, "Erroneous Assumptions: Popular Belief in the Effectiveness of Torture Interrogation," *Peace and Conflict: Journal of Peace Psychology* 13 (2007): 429–435.

[54] Amos Tversky and Daniel Kahneman, "Judgment Under Uncertainty: Heuristics and Biases," in *Judgment Under Uncertainty: Heuristics and Biases*, eds. Kahneman, Slovic, Tversky (Cambridge University Press, 1982), 465; *see also* Groopman, *supra* note 46, at 64.

Damasio)[55]—particularly when it leads interrogators and their professional advisors to value more highly information that confirms their emotional needs and desires.[56]

II. Thinking Ahead: Preliminary Reflections on Prophylaxis

The situational and systemic challenges to the ethical behaviors of health professionals in detention and interrogation environments are substantial, and there is no single solution to the problem I have described. There is also much research still to be done to determine what kinds of intervention might best serve to increase the likelihood of ethical behaviors in such unusually charged environments. That said, some tentative, non-exhaustive recommendations can and should be made. I hope that other scholars will pick up the baton, both theoretically and empirically.

Counternarratives

Before discussing measures that might be addressed to health professionals who are employed by, or consult for, the defense and national security agencies, I will comment briefly on some efforts that might be addressed by the general public. Since health professionals and their professional organizations do not operate in a vacuum, and they are subject to social influences and pressures, measures directed solely at those communities will be more effective if they are supplemented by broader social measures. One of the most important of these measures is the creation of *counternarratives* - stories (often personal stories) that challenge dominant cultural narratives.[57] Counternarratives can help combat the tendency to dehumanize detainees and can debunk simplistic notions of "them" and "us."

---

[55] Antonio Damasio, *Looking for Spinoza: Joy, Sorrow and the Feeling Brain* (Orlando: Hartcourt Inc., 2003), 40. I discuss the relationship between emotion and cognition in more detail in Marks, "What Counts," *supra* note 10.

[56] *See, e.g.,* Pat Croskerry, "Diagnostic Failure: A Cognitive and Affective Approach," Agency for Healthcare Research and Quality, *available at* http://www.ahrq.gov/downloads/pub/advances/vol2/Croskerry.pdf (last accessed August 25, 2008).

[57] *But see,* William Casebeer and James Russell, "Storytelling and Terrorism: Towards a Comprehensive Counter-Narrative Strategy," *Strategic Insights,* 4 (2005) (arguing for the use of counternarratives to dissuade terrorists and potential insurgents from violent behaviors). I argue here for the *self*-directed use of counternarratives to minimize the temptation to develop abusive detention and interrogation policies and practices and to defuse public support for such policies and practices.

In my view, it is one of the core responsibilities of a free and informed press to help craft and communicate counternarratives. I have argued at some length elsewhere about the responsibilities of the press in a deliberative democracy and about the media's shortcomings in their coverage of the run-up to the invasion of Iraq in March 2003.[58] Others have offered similar criticisms in relation to the media's initial failure to draw attention to civil liberties violations and human rights abuses of detainees at home and abroad.[59]

The tide appeared to turn after the broadcast of the photographs from Abu Ghraib on *60 Minutes* in April 2004. However, this did not redress the media's failure to cover the stories of abuse before the pictures were released. Moreover, the creation of counternarratives involves more than publishing photos. It requires giving voice to some of those who have suffered (if they choose to speak), as uncomfortable as it may be for us to hear them. Some of this work has been done in recent years by detainees' lawyers, human rights groups and academics and, as stories of abuse have unfolded, the media have picked up on them.[60] A number of filmmakers have also brought the stories of detainees to the big screen—see, for example, *The Road to Guantánamo* (2006)[61], which tells the story of three British detainees at Guantánamo Bay known as "The Tipton Three," and *Taxi to the Dark Side* (2007), a film about the Afghan taxi driver, known only as Dilawar, who died in U.S. custody at Bagram Air Base in December 2002.[62] If these stories had been told earlier, however, some of the worst abuses of detainees might perhaps have been avoided.

A more formal mechanism that has the potential to create counternarratives is the truth and reconciliation commission (TRC). In theory, a TRC could help create official counternarratives that might prevent the repeated systematic abuse of detainees in the event of another attack on the U.S. mainland. Over the last four decades, there have been dozens of TRCs, most famously in South Africa. But there is only one precedent for

---

[58] Jonathan H. Marks, "The Fourth Estate and the Case for War in Iraq," in *The Age of Apology: Facing Up to the Past,* ed. Mark Gibney et al. (2008), 298–314.

[59] Anthony Lewis, "The Responsibilities of a Free Press," *Nieman Reports* 58 (2004): 60–62.

[60] *See, e.g.,* Physicians for Human Rights, *Broken Laws, Broken Lives: Medical Evidence of Torture by the US (2007), available at* http://brokenlives.info/ (last accessed August 26, 2008); *see also* Almerindo Ojeda, *The Trauma of Psychological Torture* (Praeger Publishers, 2008).

[61] *See* Road to Guantánamo Web site, *available at* http://www.roadtoGuantánamomovie.com/ (last accessed December 15, 2008).

[62] *See* Jigsaw Productions, *Taxi to the Dark Side*, *available at* http://www.taxitothedarkside.com/ (last accessed December 15, 2008).

such a commission in the United States, and it was informal and confined to the exploration of a single event.[63] A TRC with a comprehensive mandate to explore detainee abuses would be a massive endeavor with considerable geographical challenges (given the many countries of origin of detainees in the war on terror and their families). It would also raise thorny questions about whether immunity from prosecution should be granted in return for cooperation with the commission. At the time of writing, there have been reports that the Obama Administration intends to establish some kind of nonpartisan commission with subpoena power to investigate detainee abuses in the Bush Administration's war on terror.[64] Whatever form such a commission ultimately takes, its members would do well to bear in mind that they will have an unparalleled opportunity to create some powerful but nuanced counternarratives about detainees and their captors, and that this could help prevent a recurrence of abuses in the event of another terror attack in the United States.

Debiasing

There is a substantial body of literature on debiasing,[65] some of which addresses the role that counternarratives might play in counteracting cognitive biases and preventing cognitive errors. In their recent article on "debiasing through law," Christine Jolls and Cass Sunstein argue that the best antidote to bounded rationality—as manifested by cognitive biases and resulting errors in judgment—may be to deploy the law as a debiasing tool.[66] They argue that the law might be used so that "*the environment is restructured* in a way that alters not individuals' motivations but the actual

[63] *For further information regarding the Greenshoro Truth and Reconciliation Commission*, see Greensboro Truth and Reconciliation Commission Web site, *available at* http://www.greensborotrc.org (accessed December 25, 2008).

[64] Mark Benjamin, "Obama's Plans for Probing Bush Torture," *Slate.com*, November 13, 2008, http://www.salon.com/news/feature/2008/11/13/torture_commission/print.html. The nonpartisan commission would build on and go beyond the investigation conducted by the Senate Armed Services Committee under the leadership of Senator Carl Levin. *See* Press Release Office of Senator Levin, "Senate Armed Services Committee Hearing: The Origins of Aggressive Interrogations," June 17, 2008, http://levin.senate.gov/newsroom/release.cfm?id=299242 (last accessed December 15, 2008).

[65] *For a thoughtful example, see* G. Keren, "Cognitive Aids and Debiasing Methods: Can Cognitive Pills Cure Cognitive Ills?" in *Cognitive Biases*, Caverni JP, Fabre JM, and Gonzales M eds., (North Holland, 1990), 523–52.

[66] Christine Jolls and Cass Sunstein, "Debiasing through Law," *Journal of Legal Studies* 35 (2006): 199–241.

process by which they perceive the world around them."[67] One example they discuss is the role of *optimism bias* in relation to consumer goods—that is, the tendency for people to believe their probability of facing a bad outcome is lower than it actually is. They argue that the provision of information may counteract this and note that "people tend to respond to *concrete, narrative information* even when they do not respond, or respond far less, to general statistical information."[68] So, for example, smokers are more likely to believe that cigarettes will harm their health if they are informed of specific examples of harm—stories of individual patients who have suffered—than if they are provided with cancer statistics.[69] Jolls and Sunstein then argue that "in the consumer safety context, the law might require the real-life story of an accident or injury to be printed in large type and displayed prominently so that consumers would be reasonably likely to see and read it before using the product."[70] Advancing an avowedly conservative claim, they argue in favor of narrative rather than images, because the latter "may run an especially high risk of manipulation, overshooting and other problems."[71]

Jolls and Sunstein offer their proposal as a "middle ground between inaction or naïve informational strategies, on the one hand and the 'insulating' strategies of heightened liability standards or outright bans, on the other."[72] In my view, debiasing by a variety of mechanisms, *in conjunction with* legal bans, may also serve an important function. In particular, when legal prohibitions devalue or undermine social practices, debiasing may increase compliance. The Army Interrogation Field Manual in force on 9/11 made some small effort at debiasing. It went beyond stating that certain interrogation approaches were unlawful and tried to counteract the tendency to use them – a tendency that, in my view, results from the kinds of biases articulated above. The 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

[67] *Ibid.* at 212. (Emphasis added.)
[68] *Ibid.* at 210, citing Richard E. Nisbett et al., "Popular Induction: Information Is Not Necessarily Informative," in *Judgment under Uncertainty: Heuristics and Biases,* Kahneman, Slovic, and Tversky eds., (1982), 101-116. (Emphasis added.)
[69] *Ibid.* at 212
[70] *Ibid.* at 213
[71] *Ibid.* at 215
[72] *Ibid.* at 216

to say what he thinks the interrogator wants to hear."[73] Clearly, that caution was far from effective in the Bush Administration's war on terror but, given all the other factors I have described above, this is hardly surprising.

In my view, the manuals and training for personnel assigned to the interrogation mission might be more effective at debiasing if they were to deploy some powerful counternarratives. These narratives could be offered as cautionary tales—in text boxes that would break up the flow of manuals and policy documents—and they might form the subject of pedagogical materials and discussion. Stories might be told of innocent detainees who were abused and, in some cases, died of injuries they received while in U.S. custody. (The death of Afghan taxi driver Dilawar is one of numerous lamentable examples.) Despite Jolls and Sunstein's concern about images, it may sometimes be appropriate and instructive to supplement these stories with still or moving images (in training videos, for example) in addition to recordings of oral testimony or interviews.

Other stories might demonstrate how aggressive interrogation strategies produced no actionable intelligence or spectacularly unreliable results—including "information" that was clearly fabricated or subsequently retracted once interrogational pressures were lifted. One of the most notable examples is the case of Ibn al-Shaykh al-Libi, who was rendered by the United States to Egyptian authorities, who tortured him.[74] As a result of his mistreatment, al-Libi claimed that there were links between Saddam Hussein and Al Qaeda—purported links that were used to bolster the case for war in Iraq. When al-Libi was later freed, he subsequently retracted his claims, stating that he had fabricated them to bring his torture to an end. Another potential example is the so-called "20th hijacker" Mohammed al-Qahtani, whose humiliating and life-threatening interrogation has been discussed briefly above; he has subsequently retracted much of what he said during that interrogation.[75]

---

[73] Department of the Army Headquarters, *Army Field Manual 34-52 Intelligence Interrogation* (1992), *available at* http://www.loc.gov/rr/frd/Military_Law/pdf/intel_interrogation_sept-1992.pdf (last accessed August 25, 2008). The new field manual is Department of the Army Headquarters, *Army Field Manual 2-22.3 FM 34-52 Human Intelligence Collector Operations* (2006), available at http://www.army.mil/institution/armypublicaffairs/pdf/fm2-22-3.pdf (last accessed August 25, 2008).

[74] Douglas Jehl, "Qaeda-Iraq Link U.S. Cited Is Tied to Coercion Claim," *New York Times*, December 9, 2005.

[75] Adam Zagorin, "20th Hijacker Claims That Torture Made Him Lie," *TIME*, March 3, 2006, http://www.time.com/time/nation/article/0,8599,1169322,00.html (last accessed August 25, 2008).

In contrast with these cautionary tales, narratives of effective rapport-building strategies might also be shared. Examples of these abound in both recent and distant history. Hans Scharff, the famous Luftwaffe interrogator, was renowned for his effectiveness using rapport-building techniques.[76] Similar techniques were used on this side of the Atlantic by PO Box 1142, a secret interrogation installation that operated during World War II in Fairfax, Virginia. As one former member of that unit recently explained, they "got more information out of a German general with a game of chess or Ping-Pong than they do today, with their torture."[77] Recent examples can, of course, be even more powerful. Mark Bowden, the journalist who wrote a provocative article in 2003 endorsing the aggressive interrogation of Khalid Sheik Mohammed,[78] recently appeared to have had a change of heart, and wrote a piece giving details of rapport-building interrogation tactics that led U.S. forces to Abu Musab al-Zarqawi in Iraq.[79] Stories like these can help debunk urban myths about the utility of coercion. They should be told and retold, not just during training programs, but also in the wake of any attack that is likely to provoke abuses.

Acculturation of Human Rights and Impact Assessments

Counternarratives are likely to work best when they go hand-in-hand with measures designed to achieve the acculturation of human rights.[80] In the United States, the phrase "human rights violation" is rarely used to describe detainee abuses that occur at home, although the State Department readily uses the language of human rights to describe comparable abuses that occur abroad.[81] Domestically, the language of civil liberties is more commonly

---

[76] *See* Raymond F. Toliver, *The Interrogator: The Story of Hanns Scharff, Luftwaffe's Master Interrogator* (Aero Publishers, 1978).

[77] Petula Dvorak, "Fort Hunt's Quiet Men Break Silence on WWII: Interrogators Fought Battle of Wits," *Washington Post,* October 6, 2007, A01.

[78] Mark Bowden, "The Dark Art of Interrogation," *The Atlantic*, October 2003, *available at* http://www.theatlantic.com/doc/200310/bowden (last accessed August 26, 2008).

[79] Mark, Bowden, "The Ploy," *The Atlantic*, May 2007, http://www.theatlantic.com/doc/200705/tracking-zarqawi (last accessed August 26, 2008).

[80] *See* Marks, "What Counts," *supra* note 10.

[81] *For the U.S. State Department's recent human rights country reports, see* U.S. Department of State Web site, "Human Rights," http://www.state.gov/g/drl/rls/hrrpt/ (last visited November 9, 2008). There are a number of city and state human rights commissions in the United States: for example, the New York City Commission on Human Rights (http://www.nyc.gov/html/cchr/), the San Francisco Human Rights Commission (http://www.sfgov.org/site/sfhumanrights_index.asp), and

used—perhaps because the infringement of a liberty in the name of security sounds more justifiable than a violation of human rights. As I argue at greater length elsewhere, one way of encouraging the general public to take human rights more seriously would be for the branches of government of take human rights more seriously.[82] The executive and legislative branches could do this by conducting human rights impact assessments (HRIAs, similar to environmental impact assessments) that expressly discuss and evaluate the impact of proposed counterterrorism measures on human rights.[83] (When I presented this proposal at a number of academic workshops, a few respondents suggested that, to make this suggestion politically palatable in the United States, the term "civil liberties impact assessments" would have to be used. Any form of assessment would certainly be helpful, but embracing the language of human rights and recognizing that there are several absolute norms that are binding on the United States under international law would arguably help with acculturation.)

Turning now to the military and medical professional communities, a number of additional measures can and should be taken to decrease the likelihood that health professionals will be involved in abuse and to help them act ethically in the face of countervailing social pressures that might be particularly acute in the event of another terror attack in the United States. These measures should do two things: first, they should ensure that military health professionals are better prepared to face challenging ethical decisions and, second, they must empower health professionals to make courageous decisions on the ground.[84] To achieve this, the situational and systemic factors discussed above must be addressed. Taking the high road in a stressful interrogation environment can be hard. But, as the philosopher and legal ethicist David Luban has noted, "situational changes alter the relative gradient of both the high road and the low road" and "minor manipulations of the environment can cause astonishingly large changes in the ease or

---

the Illinois Human Rights Commission (http://www.state.il.us/ihrc/). However, their remit tends to be confined to addressing complaints of discrimination in employment, real property transactions, access to financial credit, and public accommodations.

[82] *See* Marks, "What Counts," *supra* note 10.

[83] *Ibid.*

[84] In the formulation of some of the measures proposed in this section, the author is indebted to M. Gregg Bloche, "Caretakers and Collaborators," *Cambridge Q. Healthcare Ethics* 10 (2001): 275, 283 (emphasizing—months before 9/11—the need for the training of health professionals in both ethics and international human rights norms, for institutional mechanisms to nurture professional autonomy, and for international support from (among others) professional bodies).

difficulty of action, the angle of incidence between the two roads."[85]

Ethics and Policy Guidelines

For military professionals, health professionals and, of course, military health professionals, it is vital that ethics guidelines be as clear as possible. The American Medical Association and the American Psychiatric Association have prohibited their members from any involvement in individual interrogations (although both organizations permit involvement in general training activities).[86] The World Medical Association has also weighed in on the issue, prohibiting physicians from supporting any interrogation, whether legal or otherwise.[87] The American Psychological Association has been more reluctant to prohibit the direct involvement of psychologists in interrogation. Responding to pressure from grassroots movements within the organization, the Psychologists' Association issued successive resolutions in 2006, 2007, and 2008 which purport to constrain the kinds of interrogation tactics on which psychologists may advise (or in which they might otherwise become involved).[88] However, these resolutions were criticized on the grounds that they contained loopholes allowing for the continued complicity of psychologists in aggressive interrogations.[89] The tide finally turned in September 2008 when the Association's members passed a ballot resolution banning psychologists from working "in settings where persons are held outside of, or in violation of, either international law … or the U.S. Constitution, unless they are working directly for the persons being detained or for an independent third party working to protect human rights."[90] Following this resolution, the President of the American Psychological Association, Alan E. Kazdin, Ph.D., wrote to President Bush

[85] Luban, *Legal Ethics*, *supra* note 6, at 284.
[86] *See* Marks, "Doctors as Pawns?," *supra* note 3; Marks and Bloche, *Ethics of Interrogation*, *supra* note 9.
[87] *Ibid.*
[88] *See* David Luban, "Torture and the Professions," *Criminal Justice Ethics* 26 (2007): 58-66; Marks, "Doctors as Pawns?," *supra* note 3.
[89] *For a critique of the American Psychological Association's policy on interrogation and the process leading to its adoption, see* Brad Olson, Stephen Soldz, and Martha Davis, "The Ethics of Interrogation and the American Psychological Association: A Critique of Policy and Process," *Philosophy, Ethics and Humanities in Medicine* 3 (2008): 1–15. *See also* Soldz this volume.
[90] The full text of the ballot is available at APA Online, "2008 APA Petition Resolution Ballot," *available at* http://www.apa.org/governance/resolutions/work-settings.html (last accessed October 25, 2008).

informing him that the "effect of the policy is to *prohibit psychologists from any involvement in interrogations or any other operational procedures at detention sites that are in violation of the U.S. Constitution or international law*"—including Guantánamo Bay and CIA "black sites."[91]

As the protracted debate and deliberations within the American Psychological Association demonstrate, transparency in the policy-making processes of professional organizations and clarity in the ethics statements and policy guidelines that these processes produce are both vital. The presence of clarity will not remove the need for ethical analysis on the part of individual health professionals; its absence, however, may be a source of confusion or mischief (or both). Clear ethical statements from professional associations can empower health professionals working for the military or national security agencies to say no when they are asked to do something they believe to be unethical.

When professional organizations issue ethical statements after due deliberation and consultation, and those statements prohibit health professionals from acting in certain ways, the military should respect these statements. In some cases, they have clearly not done so—most notably, in relation to policies and practices in connection with interrogation and hunger strikes.[92] Efforts to circumvent or undermine the policies adopted by professional associations – most notably, the 2006 Army policy memo designed to encourage psychiatrists to participate in the design and monitoring of interrogations, despite the contrary positions taken by both the American Medical Association and the American Psychiatric Association[93] – can create doubts about the meaning and implications of those policies. The resulting confusion increases the likelihood that unethical behaviors will take place, particularly given the stressful nature of detention and interrogation environments.

Ethics Education and Mentorship

To better prepare them for challenges they may face in the future, military professionals, health professionals, and — perhaps most of all —

[91] The full text of the letter is available at APA, "Letter to President Bush," October 2, 2008, www.apa.org/releases/kazdin-to-bush1008.pdf (last accessed October 25, 2008). (Emphasis in original.)
[92] *See* Marks and Bloche, "Ethics of Interrogation," *supra* note 9; George J. Annas, "Military Medical Ethics—Physician First, Last, Always," *N. Engl. J. Med*. 359 (2008): 1087–1090.
[93] *See* Marks and Bloche, "Ethics of Interrogation," *supra* note 9.

military health professionals should have better training in international humanitarian law and human rights law. These fundamental legal norms should form the baseline of health professionals' ethical obligations,[94] and health professionals should be well-educated about them. In a recent study of 5,000 medical students, 94% had received less than an hour's instruction on the Geneva Conventions.[95] Little more than a third of respondents knew that the Conventions would require them to treat the sickest first, irrespective of nationality. A similar percentage were unable to say when they were required to disobey an unethical order—some even thought they could inject a fearful prisoner with saline solution knowing the prisoner had been led to believe he was receiving a lethal injection.[96] Knowledge of international legal norms does not per se lead to respect for or compliance with them. In a survey conducted by the Pentagon of 1700 soldiers in Iraq between August and October 2006, less than half thought that Iraqi civilians should be treated with dignity and respect, and more than a third believed torture was acceptable if it might save the life of a fellow soldier or procure information about insurgents.[97] (Apparently, the respondents were more familiar with *24* than with the experts' views about the inefficacy of torture.) Military health professionals should be forewarned of the social pressures that arise from working in such an environment and prepared for the resulting ethical challenges.

Two additional points about ethics education should be noted. First, ethics education is not just about learning codes of ethics. Comprehensive ethics education should perform at least three functions. It should aim to develop ethical sensitivity (in particular, the ability to spot ethical issues), improve ethical reasoning skills, and foster the kind of moral imagination that can lead to creative solutions to complex problems.[98] Second, there is some evidence that ethics education alone is not sufficient.[99] Mentorship

---

[94] *See* Marks, "Doctors as Pawns?," *supra* note 3.

[95] J. Wesley Boyd et al., "US Medical Students Knowledge About the Military Draft, the Geneva Conventions and Military Medical Ethics," *International Journal of Health Services* 37 (2007): 634–650.

[96] *Ibid.*

[97] Humphrey Hawksley, "US troops 'condone torture,'" *BBC News,* May 4, 2007, *available at* http://news.bbc.co.uk/2/hi/middle_east/6627055.stm (last accessed August 26, 2008).

[98] Nancy Tuana, "Conceptualizing Moral Literacy," *Journal of Educational Administration* 45 (2007): 364-378.

[99] M. Anderson, et al., "What do Mentoring and Training in the Responsible Conduct of Research have to do with Scientists' Misbehavior? Findings from a National Survey of NIH-Funded Scien-

is also important, but it has to be the right kind of mentorship. Mentors who communicate subtle messages that seek to undermine the relevance or importance of ethical norms are likely to induce unethical behaviors. By contrast, mentors who encourage others to take ethical obligations seriously may increase the likelihood that their colleagues will behave ethically.[100]

Structural Reforms

Structural incentives are also required if we are to expect military health professionals to act ethically, despite the many other countervailing situational pressures. The precise formulation of these measures should be addressed by a panel of experts. This panel should include members with knowledge of military and medical structures and should consult widely and publicly with others. There are a number of measures such a panel would need to consider, among them hotlines or help-lines. In my view, if these were put in place and were well publicized—both within the military and within the relevant professional organizations—they would provide a vital resource for professionals who believe that they are being asked to act unethically.[101] In addition, whistleblowing must be encouraged and rewarded.[102] Taking this seriously may be a challenge to both medical and military culture. It requires the encouragement of dissent and the recognition that dissent may be more patriotic than silence or acquiescence. If potential whistleblowers are concerned about the career and financial implications of speaking out (as is likely to be the case for many military health professionals for the reasons described above), measures should be put in place to limit the potential adverse consequences for bona fide whistleblowing—and to assure potential

tists," *Academic Medicine* 82 (2007): 853–860.

[100] Arrigo and Bennett, *supra* note 28 (advocating similar mentorship for interrogators to ensure the communication and acculturation of ethical norms).

[101] *For similar recommendations designed to address a distinct (but not entirely unrelated) source of social pressure and ethical challenges for health professionals, see* Jonathan H. Marks, "Expedited Industry-Sponsored Translational Research: A Seductive but Hazardous Cocktail?," *American Journal of Bioethics* 8 (2008): 56–58.

[102] This does not mean "outing" a whistleblower or otherwise exposing him or her to potential harm. Although Joseph Darby, the whistleblower at Abu Ghraib, had been promised anonymity, his identity was disclosed on national television by then-Secretary of Defense Donald Rumsfeld who ostensibly thanked him. At the time, Derby was sitting in a crowded canteen in Iraq with hundreds of his fellow soldiers; as a result, he had to be whisked away for his own safety. *See* Dawn Bryan, "Abu Ghraib Whistleblower's Ordeal," *BBC News.com,* Aug. 5, 2007, *available at* http://news.bbc.co.uk/2/hi/middle_east/6930197.stm (accessed August 29, 2008).

beneficiaries of their efficacy.

Accountability

Finally, taking measures to hold wrongdoers accountable can send important signals to others. If speaking out is the only course of action that entails social and other costs, even "good people" are more likely to remain silent. But if complicity or acquiescence is perceived as having serious costs, military health professionals may be more likely to stand up and speak out. For this reason, it is important that military health professionals who have participated or were complicit in the egregious abuse of detainees be held accountable. In the most extreme cases, this may mean courts martials or criminal prosecution. But accountability will also require disciplinary action by the appropriate licensing bodies—in the United States, the state licensing boards. To date, no military health professionals have been prosecuted for complicity in detainee abuses in the war on terror. There have been several calls for disciplinary accountability on both sides of the Atlantic, and numerous complaints have been lodged with professional associations, as well as with licensing boards.[103] However, none of these has led to any sanctions to date.[104] Unless these cases are formally investigated, it is likely that complainants and human rights activists will take measures to achieve informal or social accountability—such as building public databases that collate documentary and affidavit evidence of the alleged involvement of named health professionals in the abuse of detainees.[105]

III. Conclusion

At the time of writing, there has not yet been another terrorist attack on the mainland United States since 9/11. This may be more a matter of good fortune than anything else. Whatever the explanation, it seems highly likely that there will be another attack at some time in the foreseeable future. In the event of such an attack, the temptation to use aggressive interrogation strategies is likely to recur—perhaps with even greater force. Whether

[103] *For a more detailed discussion of accountability, see* George Annas, "Human Rights Outlaws: Nuremberg, Geneva and the Global War on Terror," *Boston U. Law Rev*. 87 (2007): 427–466.
[104] *Ibid.*
[105] *Ibid.*

we succumb to that temptation again will depend, in part, on whether we explore the measures discussed in this chapter. Some of these measures are directed at the population at large, but others focus on health professionals who are employed by the military or various intelligence agencies. These professionals could provide us with the best opportunity we have of avoiding a repetition of some of our worst mistakes. We must educate, mentor and empower them to be guardians of human rights and to say no to any practice or environment that violates these fundamental norms. If we fail to do this, we will do a great disservice to them, to those they harm (or, at the very least, fail to protect), and – ultimately – to ourselves.