The Nation.

The browser-optimized version of this article can be found on the web at
http://www.thenation.com/doc/20051226/marks

The Silence of the Doctors

by JONATHAN H. MARKS

[from the December 26, 2005 issue, printed and posted on the web December 7, 2005]

It was called the "water cure." But it was dosed out liberally to those who weren't sick. Unfortunate recipients were held by the neck beneath a water tank. The tap was turned on, and they were forced to swallow the gushing stream--or to choke within an inch of death while trying. Another variation used tubing to siphon water from a kerosene can into a detainee's nostril. Sworn testimony records the use of this tactic in the presence of a doctor. It was, after all, a "cure." When the detainee still refused to talk, the doctor would ratchet up the treatment, ordering a second tube to be placed in the detainee's other nostril and a handful of salt to be thrown into the water. Anyone who's ever had sea water up his or her nose will know just how pleasant that would have been.

This interrogation tactic comes not from the "war on terror" but from the war in the Philippines more than 100 years ago. There too the abuses were justified by the need to combat troublesome local "insurgents." The enemy was "not civilized" and did not deserve to be treated according to the rules of civilized warfare. The water cure is, of course, the precursor to a more recent interrogation technique known as "waterboarding." And the participation of the physician is an early example of American medical personnel being co-opted into an egregious and unlawful military mission. The doctor's presence did not restrain the interrogator's excesses; on the contrary, he actively fueled them.

After 9/11 some American healthcare personnel were once again asked to step into the breach and help Army interrogators conduct aggressive interrogations. They have, among others, Maj. Gen. Geoffrey Miller--former camp commander at Guantánamo Bay--to thank for this. Miller considered the participation of Behavioral Science Consultation Teams--known colloquially as "Biscuits"--to be an "essential" part of the interrogation process. Having introduced the first Biscuit to the Guantánamo facility in late 2002, Miller urged the deployment of a similar team at Abu Ghraib in late 2003. These Biscuits were staffed at various times by psychologists and/or psychiatrists.

The Defense Department has acknowledged that several Biscuit staff were sent to Fort Bragg, North Carolina, for training at SERE school--short for Survival, Evasion,

Resistance and Escape. This is where American soldiers are taught how to resist their captors. Training is based on exposure to abusive tactics, some tantamount to torture, delivered by fellow soldiers. (That these tactics are designed to break detainees and procure false confessions--not to produce intelligence--appears to have been overlooked by the Administration when it decided to deploy them in the "war on terror.") At SERE school, Biscuit healthcare personnel acquired a grounding in the now well-publicized techniques of hooding, prolonged isolation, stress positions, sleep deprivation and exposure to loud noise and temperature extremes--techniques often used in combination.

They brought this knowledge back to Guantánamo Bay, where--according to an internal Army report--they offered opinions on the character and personalities of detainees, advised on interrogation plans and approaches, and provided feedback on interrogation technique. Army documents also record that Biscuit personnel sometimes sat in on interrogations. Notably, the name of a Biscuit psychologist appears in the interrogation log of Guantánamo detainee Mohammed al-Qahtani. According to that log--a copy of which was obtained by *Time* magazine--Qahtani was questioned for eighteen to twenty hours per day for forty-eight out of fifty-four consecutive days in late 2002 and early 2003. During that time, he was subjected to an array of tactics that included exposure to temperature extremes, barking military dogs, strip searches, stress positions, being led around on a leash and being forced to stand naked in front of women. In addition to these measures--many of which were held "legally permissible" in a recent Army report--a medical corpsman forcibly administered three and a half bags of intravenous fluid. Qahtani was refused a promised bathroom break and, when he became desperate, he was told to go in his pants.

Before this interrogation regime, Qahtani had been subjected to 160 days of isolation and--according to a letter of complaint sent by the FBI to the Pentagon--he was "evidencing behavior consistent with extreme psychological trauma." Not surprisingly, this trauma was compounded by the deleterious impact the interrogation tactics had on Qahtani's physical health. On one occasion, his heartbeat became so slow--just thirty-five beats per minute instead of the normal sixty to 100--that he had to be hospitalized. On at least two occasions, his temperature dropped to a life-threatening ninety-five degrees.

Aggressive interrogations like those endured by Qahtani were based on a model that seeks to employ extreme levels of stress in order to erode established patterns of behavior, such as resistance to questioning. One of the functions of Biscuit health professionals is to help interrogators tailor interrogation "stressors" to the personality of each detainee--particularly "high-value detainees." In one example--reported by Neil Lewis in the *New York Times*--interrogators were told by a Biscuit that a detainee's medical files recorded his severe phobia of the dark, and the Biscuit suggested ways that fear could be manipulated to make the detainee cooperate.

Much ink has been spilled--by me and others--explaining why these practices violate fundamental rules and protections found in both the laws of war and international human rights law. These two bodies of law prohibit most of the aggressive interrogation strategies deployed in the "war on terror"--and mandate the humane treatment of

detainees. The Administration has tried its best to circumvent these laws. It argues, for example, that the ban on cruel, inhuman and degrading treatment doesn't apply to foreigners outside the United States--a position the McCain amendment seeks to overturn. This amendment is all the more important in light of the Defense Department's new Interrogation Directive. The directive was greeted warmly in the press with headlines like "Pentagon: Detainees Must Be Treated Well" (AP). It prohibits the use of military dogs and requires interrogations to be humane and in accordance with "relevant" international law (whatever that may be). But read the fine print: It also expressly provides that Defense Secretary Rumsfeld or his deputies may authorize interrogations that do not meet either of these basic criteria.

When medical personnel are involved in interrogation, medical ethics should also have something to say. And when the Administration plays around with legal rules, it is all the more important for the medical establishment--and its members--to take an ethical stand. Medical ethics should embrace and reflect the fundamental protections found in human rights law and the laws of war, as the UN has recognized. According to a resolution of the General Assembly adopted without dissent in 1982, it is a "gross contravention of medical ethics" for health professionals to be complicit in torture or cruel, inhuman or degrading treatment. They are also required not to use their knowledge and skills to assist with an interrogation that may adversely affect a detainee's health and is not in accordance with international law. Medical personnel who helped design and monitor aggressive interrogations like those of Qahtani have undoubtedly fallen afoul of this ethical mandate.

But ethical constraints can and should go beyond the requirements of law. The World Medical Association has acknowledged this and holds that--even in times of armed conflict--it is unethical for physicians to weaken the physical or mental health of a human being "without therapeutic justification." Its codes also emphasize that detainee medical records are presumed to be confidential. This presumption--universally acknowledged as being vital to patient trust and effective medical care--was violated by the routine exploitation of medical records during interrogations at Guantánamo. The association's rules also prohibit force-feeding hunger-strikers--a rule now broken daily at Guantánamo. Although the Defense Department has denied the shocking claim that a finger-thick nasogastric tube was reused without sterilization in order to feed different detainees at the facility, it readily admits that force-feeding is occurring.

The Pentagon has recently taken steps to alleviate concerns about the involvement of medical personnel in abuse. In June it issued new medical "procedures" for detainees in US custody. These prohibit healthcare personnel from participating in interrogations not in accordance with "applicable law." But what law is "applicable"? More pertinent, what law is applicable according to an Administration that does not shy away from developing its own highly permissive formulations of legal doctrine? In September the Defense Department issued a further "special text" stating that Biscuit members should not have access to medical records "except as needed to maintain safe, legal and ethical interrogations." But anyone familiar with previous abuses must have concerns about how that constraint will be enforced. In October the Pentagon flew officials from several

health professional organizations to Guantánamo. Like the typical Defense Department tour of Guantánamo, it was a six-hour visit. Guests were armed with packs of information and given multiple briefings, but they were not permitted to talk to detainees--a prohibition that recently led UN human rights experts to cancel their Guantánamo visit.

These measures may not have had the effect the Administration hoped for. Following the Guantánamo trip, Dr. Steven Sharfstein, president of the American Psychiatric Association, stated publicly that it was "inappropriate" for psychiatrists to serve on Biscuits. The APA's board is soon expected to adopt changes to its rules that will make this official policy. Sharfstein's concerns extend beyond aggressive interrogations. In his view, all Guantánamo interrogations are tainted by the detention of the subject in legal limbo and, more than that, he doesn't want his members participating in or advising on any inherently deceptive interrogation tactics.

Other groups--not least, Physicians for Human Rights and Physicians for Social Responsibility--have also been vocal in their condemnations of medical participation in abusive practices at Guantánamo Bay and elsewhere. The responses of two of America's core medical professional organizations, the American Medical Association and the American Psychological Association, however, raise serious concerns.

The performance of the AMA--the organization that spoke out so firmly in response to the abuses of Nazi doctors--has been especially shocking. After the Guantánamo tour, it declined to make its representative on that trip, Dr. Audiey Kao, available to the *New York Times* for comment. The AMA was also slow to express support for the McCain amendment, doing so only after other medical groups had spoken out and its silence became embarrassing. One reason for the AMA's lack of resolve is its members' concerns about other issues--topics more relevant to their daily practice. Hundreds of resolutions are brought by members every year on issues ranging from tort "reform" to Medicare. But only two resolutions in the past year addressed the interrogation issue. The result was a decision in November to commission a report from the AMA's ethics body, which won't appear until June 2006 at the earliest. That concerns about the level of Medicare reimbursements--currently under consideration on the Hill--are preventing the AMA from speaking out on an issue that goes to the heart of what it means to be a physician (whether for fear of offending the government or exhausting the group's political capital) should be a source of shame.

The American Psychological Association has been quicker to act, producing guidance drafted by its Presidential Task Force in June. But the task force was stacked predominantly with psychologists who work or have worked for the military--in some cases at SERE school. Although the resulting guidelines require psychologists not to facilitate torture or cruel, inhuman or degrading treatment, they adopt as a "touchstone" US rules and regulations as "developed and refined" in the "war on terror." Despite the association's subsequent support of the McCain amendment, this makes psychologists' ethical constraints appear dependent upon the Administration's manipulation of legal doctrine and, in particular, on its views about the scope and content of the ban on cruel, inhuman and degrading treatment. Just as important, the task force also failed to require

psychologists to respect the fundamental human rights of detainees established in international law. Rather than giving psychologists firm guidelines, the task force tells them to be mindful of factors that "require special ethical consideration" when consulting on interrogation. But leaving psychologists to make ad hoc decisions in military scenarios--when they are dependent on others for information and have neither the time nor the competence to assess it--is not a good recipe for preventing future abuses. Since the Defense Department has deployed psychologists rather than psychiatrists on Biscuits recently--sensing, perhaps, that their ethical constraints may not be as rigorous--it is especially important that the shortcomings in these guidelines be addressed.

But all bodies within the medical establishment should lay down rules that directly address the participation of their members in the design and monitoring of interrogations. Clear rules drafted with real-world scenarios in mind are vital if we are to empower medical personnel to say no when asked to participate in future abuses.

Moving forward, however, also requires looking back. At least four Guantánamo detainees have lodged a complaint against Dr. John Edmondson, head of the facility's Naval hospital. They allege that physicians under Edmondson's supervision made medical care contingent on cooperation with interrogators, that they witnessed and participated in abuse and that they shared medical information with interrogators to expose detainees' weaknesses. The Medical Board of California has refused to entertain the complaint on procedural grounds. The board says it can't consider the complaint because the alleged conduct occurred outside its jurisdiction, on a military base. By that rationale, a lawyer could be guilty of serious misconduct in California and still practice at the New York bar. This point has not escaped Scott Sullivan, the attorney representing the detainees. He has asked the California courts to compel the Medical Board to hear the complaint. That it should come to this is more than unfortunate.

Although it is the job of the medical community to regulate its own, and to call to account the few who threaten to tarnish the reputation of the many, a full and independent investigation into detainee abuses and the role of medical personnel in those abuses is also needed. An "assessment" report of detainee medical activities made public by the Army Surgeon General in July raised more questions than it answered. What did the seventy-four medical personnel--in Iraq alone--who admitted witnessing interrogations actually see? What do the detainees who were the subjects of those interrogations--and who were not interviewed for the report--have to say about the involvement of those personnel? More generally, how were some medical personnel co-opted into a policy of detainee abuse after 9/11? Demanding answers to these questions is essential, not just for the integrity of the medical community but for the health of our democracy.

Jonathan H. Marks is a barrister at Matrix Chambers, London, and a veteran of the Pinochet case. He is currently Greenwall Fellow in Bioethics at Georgetown University Law Center and Johns Hopkins School of Public Health. His work (with M. Gregg Bloche) on the role of medical personnel in interrogation has appeared in *The New England Journal of Medicine*, the *New York Times* and the *Los Angeles Times*.