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Doctors and Interrogators at Guantanamo Bay

Mounting Evidence of Torture

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Theme: Crimes against Humanity

Mounting evidence from many sources, including Pentagon documents, indicates that military interrogators at Guantanamo Bay have used aggressive counter-resistance measures in systematic fashion to pressure detainees to cooperate. These measures have reportedly included sleep deprivation, prolonged isolation, painful body positions, feigned suffocation, and beatings. Other stress-inducing tactics have allegedly included sexual provocation and displays of contempt for Islamic symbols. (1) The International Committee of the Red Cross (ICRC) and others charge that such tactics constitute cruel and inhuman treatment, even torture.

To what extent did interrogators draw on detainees' health information in designing and pursuing such approaches? The Pentagon has persistently denied this practice. After the ICRC charged last year that interrogators tapped clinical data to craft interrogation strategies, Defense Department officials issued a statement denying "the allegation that detainee medical files were used to harm detainees."(2) This spring, an inquiry led by Vice Admiral Albert T. Church, the inspector general of the U.S. Navy, concluded: "While access to medical information was carefully controlled at GTMO [Guantanamo Bay], we found in Afghanistan and Iraq that interrogators sometimes had easy access to such information."(3) The implication is that interrogators had no such access at Guantanamo and that medical confidentiality was shielded, albeit with exceptions. Other Pentagon officials have reinforced this message. In a memo made public last month, announcing "Principles . . . for the Protection and Treatment of Detainees," William Winkenwerder, the Assistant Secretary of Defense for Health Affairs, said that limits on detainees' medical privacy are "analogous to legal standards applicable to U.S. citizens." But this claim, our inquiry has determined, is sharply at odds with orders given to military medical personnel â€" and with actual practice at Guantanamo. Health information has been routinely available to behavioral science consultants and others who are responsible for crafting and carrying out interrogation strategies. Through early 2003 (and possibly later), interrogators themselves had access to medical records. And since late 2002, psychiatrists and psychologists have been part of a strategy that employs extreme stress, combined with behavior-shaping rewards, to extract actionable intelligence from resistant captives.

A previously unreported U.S. Southern Command (SouthCom) policy statement, in effect since August 6, 2002, instructs health care providers that communications from "enemy persons under U.S. control" at Guantanamo "are not confidential and are not subject to the assertion of privileges" by detainees. The statement, from SouthCom's chief of staff, also instructs medical personnel to "convey any information concerning . . . the accomplishment

of a military or national security mission . . . obtained from detainees in the course of treatment to non-medical military or other United States personnel who have an apparent need to know the information. Such information," it adds, "shall be communicated to other United States personnel with an apparent need to know, whether the exchange of information with the non-medical person is initiated by the provider or by the non-medical person." The only limit this policy imposes on caregivers' role in intelligence gathering is that they cannot act as interrogators.

The statement, embedded â€" along with policies on parking and alcohol â€" in the personnel section of the SouthCom Web site,(4) not only requires caregivers to provide clinical information to military and Central Intelligence Agency interrogation teams on request; it calls on them to volunteer information that they believe might be of value. It thereby makes them part of Guantanamo's surveillance network, dissolving the Pentagon's purported separation between intelligence gathering and patient care.

Rather than being consistent with the presumption of confidentiality that applies to Americans even in prisons, the Guantanamo policy rejects this presumption. Within military prisons, personal health information cannot be given to correctional or law-enforcement officials unless they deem it necessary for health, safety, or security reasons. Confidentiality is also the starting point in federal and state prisons for civilians, albeit with similar exceptions for health, safety, and security. (Federal law permits disclosure of inmates' health information "to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.") There is debate over the scope of these exceptions, but there is consensus about the basic presumption of medical privacy.

Wholesale rejection of clinical confidentiality at Guantanamo also runs contrary to settled ethical precepts. Medical privacy is not an ethical absolute â€" caregivers in civilian and military settings have an obligation to report information to third parties when doing so can avert threats to the health or safety of identifiable persons â€" but confidentiality is the starting premise.

The laws of war defer to medical ethics. Additional Protocol I to the Geneva Conventions provides that medical personnel "shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics." Although the protocol has not been ratified by the United States, this principle has attained the status of customary international law. International human rights law (most important, the 1966 International Covenant on Civil and Political Rights) provides additional protection for privacy in general â€" in wartime and peacetime. Although this protection isn't absolute, exceptions must be justified by pressing public need, and they must represent the least restrictive way to meet this need. Wholesale abandonment of medical confidentiality hardly qualifies, especially when the "need" invoked is the crafting of counter-resistance measures that are prohibited by international law.

In what ways did military intelligence personnel draw on medical information for interrogation and counter-resistance purposes? Instructions to Guantanamo veterans not to discuss their service publicly have been an obstacle to answering this question. But available documents, an account of a fall 2004 briefing by the camp's commander (Brigadier General Jay Hood), and interviews with behavioral science professionals enable us to assemble parts of this picture.

During the camp's early months, interrogators could gain access to personal health

information (and did so to set limits on practices that might put detainees' health at risk) but did not use psychological assessments of individual subjects. Conventional army intelligence doctrine has been unsympathetic to such input: it has relied instead on a mix of standard interrogation methods meant to appeal variously to subjects' insecurities, pride, and fears, within constraints set by the laws of war.(5) But by late 2002, growing frustration with the slow pace of intelligence production at Guantanamo led to calls from commanders for innovative tactics. Major General Geoffrey Miller, who took command of Guantanamo in late 2002, approved the creation of a "Behavioral Science Consultation Team" (BSCT, pronounced "Biscuit") in order to develop new strategies and assess intelligence production. A principal BSCT function was to engineer the camp experiences of "priority" detainees to make interrogation more productive.

A psychiatrist and a psychologist staffed the Guantanamo BSCT. Those initially assigned to this team both came from health care backgrounds; neither had much training in behavioral analysis of the sort that civilian psychologists perform for law-enforcement agencies. According to Hood's briefing, BSCT consultants prepared psychological profiles for use by interrogators; they also sat in on some interrogations, observed others from behind one-way mirrors, and offered feedback to interrogators. The first BSCT psychologist, Major John Leso, a specialist in assessing aviators' fitness to fly, attended part of the interrogation of Mohammed al-Qahtani, thought by many to be the "20th hijacker." (An extract from a log of this interrogation published in Time magazine last month refers to Leso as "Maj. L.")

There are strong indications that the Guantanamo BSCT has had access to personal health information. An internal, May 24, 2005, memo from the Army Medical Command, offering guidance to caregivers responsible for detainees, refers to the "interpretation of relevant excerpts from medical records" for the purpose of "assistance with the interrogation process." The memo, provided to us by a military source, acknowledges this nontherapeutic role, urging health professionals who serve in this capacity to avoid involvement in detainee care, absent an emergency. This acknowledgment is consistent with other accounts of information flow from caregivers to behavioral science consultants to interrogators.

Competing behavioral science models have influenced the advice given to interrogators by BSCT members. One approach emphasizes fear and anxiety as counter-resistance tools; another favors rapport with detainees. The former approach, supported by some associated with the John F. Kennedy Special Warfare Center who have helped to formulate BSCT doctrine, builds on the premise that acute, uncontrollable stress erodes established behavior (e.g., resistance to questioning), creating opportunities to reshape behavior. Complex reward systems (e.g., the creation of multiple camp "levels" with different privileges) promote cooperation. Stressors tailored to the psychological and cultural vulnerabilities of individual detainees (e.g., phobias, personality features, and religious beliefs) are key to this approach and can be devised on the basis of detainee profiles.

Proponents of rapport-based interrogation counter that answers given under high stress are unreliable. Not only are people in acute distress inclined to say whatever they think might bring relief; the psychiatric sequelae of extreme stress â€" anxiety, depressed mood, and disordered thinking â€" impair the understanding of questions and produce incoherent answers. Rapport building, tailored to people's cognitive styles and cultural beliefs, takes time but yields better information, its defenders contend.

There is no scientific answer to the question of which interrogation strategy is more effective. For obvious ethical and legal reasons, there is unlikely to be one. At Guantanamo,

the fearand- anxiety approach was often favored. The cruel and degrading measures taken by some, in violation of international human rights law and the laws of war, have become a matter of national shame.

Clinical expertise has a limited place in the planning and oversight of lawful interrogation. Psychologists play such a role in criminal investigations, and medical monitoring of detainees is called for by international legal instruments. But proximity of health professionals to interrogation settings, even when they act as caregivers, carries risk. It may invite interrogators to be more aggressive, because they imagine that these professionals will set needed limits. The logic of caregiver involvement as a safeguard also risks pulling health professionals in ever more deeply. Once caregivers share information with interrogators, why should they refrain from giving advice about how to best use the data? Won't such advice better protect detainees, while furthering the intelligence- gathering mission? And if so, why not oversee isolation and sleep deprivation or monitor beatings to make sure nothing terrible happens?

Wholesale disregard for clinical confidentiality is a large leap across the threshold, since it makes every caregiver into an accessory to intelligence gathering. Not only does this undermine patient trust; it puts prisoners at greater risk for serious abuse. The global political fallout from such abuse may pose more of a threat to U.S. security than any secrets still closely held by shackled internees at Guantanamo Bay.

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An interview with Mr. Marks can be heard at www.nejm.org

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