

Doctors as Pawns? Law and Medical Ethics at Guantánamo Bay

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I. INTRODUCTION

This symposium poses the question: “Guantanamo Bay: How should we respond?” When I thought about this question, it occurred to me that we talk about “responding” in a number of ways. We respond in games, such as chess or bridge. But the detention policy of the Bush Administration (“the Administration”) is not a game—certainly not from the perspectives of those who are being (or have been) detained at Guantánamo Bay for prolonged periods since the “global war on terror” began. We also respond in conversation. However, we should not permit rhetoric to distract from action on the ground. Statements of interrogation and detention policy are one thing (especially when prepared for public consumption or in response to public criticism); interrogation and detention practices may be quite another. We respond in negotiation. That model, too, makes me uncomfortable. My intuition and my legal training tell me that some things should simply not be negotiable, among them certain absolute commitments to fundamental human rights: freedom from cruel, inhuman, and degrading (“CID”) treatment, as well as freedom from torture. This is, after all, the position adopted in two core human rights treaties: the International Covenant on Civil and Political Rights (“ICCPR”),¹ and the Convention against Torture and

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¹ G.A. Res. 2200A (XXI), 21 U.N. GAOR, Supp. No. 16, at 52, U.N. Doc. A/6316 (Dec. 16, 1966), *available at* http://www.unhchr.ch/html/menu3/b/a_ccpr.htm (stating in Article 4 that there can be no derogation from the prohibitions on either

Other Cruel, Inhuman or Degrading Treatment or Punishment (“Torture Convention”).² Finally, and perhaps most charitably, our “response” may be viewed as part of the political process—as deliberative democracy taking its natural course. But the political process seems to be taking far too long. There are detainees at Guantánamo who have been in United States custody for five years, and every additional day of detention deepens the profound psychological impact on them.³ Three of the Guantánamo detainees have already taken their own lives.⁴ Additionally, at least twenty-five detainees have failed in their suicide attempts (in some cases, multiple attempts),⁵ while many more are clinically depressed.⁶

As I contemplated my own response to the Administration’s counterterrorism policy for this symposium, I became preoccupied with three major concerns. First, despite my comments above, the treatment of detainees at Guantánamo and elsewhere does appear to have evolved into a kind of multi-party, multi-dimensional game of chess. The familiar array of players includes the three branches of government and the Fourth Estate—at times critical, but often stenographic⁷—as well as lawyers, academics, and members of human rights and civil liberties groups. However, health professionals at Guantánamo Bay—whether nominally serving in a care-giving capacity or as adjuncts to the interrogation mission—are also involved, as are their professional organizations.⁸ A related concern, which I articulate further below, is that health professionals—whether physi-

torture or cruel, inhuman, or degrading treatment even “[i]n time of public emergency which threatens the life of the nation”).

² G.A. Res. 39/46, annex, 39 U.N. GAOR, Supp. No. 51, at 197, U.N. Doc. A/39/51 (Dec. 10, 1984) (stating in Article 2(2) that “[n]o exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture”).

³ See generally PHYSICIANS FOR HUMAN RIGHTS, BREAK THEM DOWN: SYSTEMATIC USE OF PSYCHOLOGICAL TORTURE BY US FORCES 48–71 (2005), available at <http://www.physiciansforhumanrights.org/library/documents/reports/break-them-down-the.pdf> (explaining the long-term psychological impact of prolonged isolation and aggressive interrogation procedures).

⁴ Josh White, *Three Detainees Commit Suicide at Guantanamo*, WASH. POST, June 11, 2006, at A01.

⁵ *Id.*

⁶ It has been reported that one-fifth of Guantanamo detainees are on anti-depressants. See, e.g. Editorial, *Inside Guantanamo: How We Survived Jail Hell*, OBSERVER (London), Mar. 14, 2004, available at http://observer.guardian.co.uk/uk_news/story/0,6903,1168937,00.html.

⁷ See Jonathan H. Marks, *Apology or Apologia: The Fourth Estate and the Case for War in Iraq*, in THE AGE OF APOLOGY: THE WEST FACES ITS OWN PAST (Gibney et al. eds., 2007).

⁸ The role of professional organizations will be discussed in Part IV, *infra*.

cians, psychologists, nurses, medics, or others—who have served or now serve at Guantánamo Bay, have become pawns in the mistreatment of detainees and in the debate over their treatment.

Second, a substantial part of the “game” of politico-legal move and countermove has involved the re-interpretation of the scope, meaning, and application of legal norms—particularly international legal norms. Three of the most conspicuous casualties in this process have been the definition of torture, the prohibition of cruel, inhuman, and degrading treatment and punishment, and the basic protections in Common Article Three of the Geneva Conventions.⁹ When legal protections for detainees are being undermined, it is all the more important that professional ethics (in particular, medical ethics) speak clearly and that codes of ethics do not become subordinate to, or dependent upon, unilateral reinterpretations of legal doctrine. The ethics of health professionals should embrace fundamental standards of human rights and the laws of war, as recognized and interpreted by the international legal order in whose formation the United States played such a pivotal role.¹⁰ However, if health professionals are to retain our trust, and if they are to maintain the social and cultural status engendered by their perceived humanitarian ethos, their codes of ethics should do more than simply reflect the most fundamental legal prohibitions.

Third, the focus on Guantánamo Bay conveniently distracts attention from other detention centers, such as Bagram in Afghanistan and numerous unidentified “black sites” operated by the Central Intelligence Agency (“CIA”) across the globe¹¹—where interrogation practices and the role of health professionals have come under far less public scrutiny. There is a danger that Guantánamo Bay has or will become a staged detention center, while more egregious treatment of detainees is conducted elsewhere. Following the first newspaper reports about the existence of these “black sites” operated by the CIA, one experienced U.S. interrogator observed:

Its [sic] so nice to be secret. No trouble over human rights. So secret that most of the military or government have no idea where they are. No rights, human or otherwise have to be dealt with.

⁹ See, e.g., Geneva Convention Relative to the Treatment of Prisoners of War, art. 3, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135 (“Third Geneva Convention”).

¹⁰ See Jonathan H. Marks, *Uphold International Law*, RALEIGH NEWS & OBSERVER, Feb. 16, 2003, at A29 (noting the irony of the United States’ efforts to undermine the international legal order that the United States worked so hard to establish).

¹¹ The President admitted the existence of these sites in September 2006. See Dan Eggen & Dafna Linzer, *Secret World of Detainees Grows More Public*, WASH. POST, Sept. 7, 2006, at A18 (noting that details of the sites remain classified).

Let a few inaccessible places be released through controlled media informants and then AI [Amnesty International] and all the rest will be concentrating on those places while we continue to work in the real centers.¹²

Since details of these detention centers remain undisclosed and classified, it is difficult to say much about the role of medical professionals at those sites. Although we can speak with some degree of confidence about their role at Guantánamo Bay, we should keep in mind that we are only talking about one piece of the interrogation picture.

II. HEALTH PROFESSIONALS AND INTERROGATION AT GUANTÁNAMO

It is possible to describe in some detail the roles that health professionals played in the design and implementation of interrogation strategies at Guantanamo Bay thanks to the tens of thousands of documents obtained by the American Civil Liberties Union (“ACLU”) under the Freedom of Information Act (“FOIA”), not to mention several other documents that have been leaked to the press. Since these roles have been described in considerable detail elsewhere,¹³ I review them only briefly here.

Psychiatrists and psychologists were brought into the interrogation process not as gatekeepers or health care advocates for detainees, but as adjuncts to the interrogation mission. Although some of them clearly had no professional background or training relevant to interrogation,¹⁴ they were considered “behavioral science consult-

¹² Correspondence between a U.S. Counterintelligence Liaison Officer and Jean Maria (2002–2005) (on file at the Project on Ethics and Art in Testimony, Irvine, CA) [hereinafter Arrigo Papers]. An additional copy is archived at *Intelligence Ethics Collection*, Hoover Institution Archives, Stanford University, Stanford, CA (restricted until January 1, 2010). This is, of course, just one interrogator’s view of human rights. The correspondence also indicates that there have been deliberate efforts to distract and mislead the press during the war on terror. Another communication states: “[E]mbedded reporters are now being put in one vehicle and taken to staged events while the rest of the unit goes to do its job The use of names of the prisoners will be replaced by codes so nobody can try to trace them.” *Id.*

¹³ See, e.g., M. Gregg Bloche & Jonathan H. Marks, *When Doctors Go To War*, 352 *NEW ENG. J. MED.* 3, 3–6 (2005); M. Gregg Bloche & Jonathan H. Marks, *Doctors and Interrogators at Guantanamo Bay*, 353 *NEW ENG. J. MED.* 6, 6–8 (2005); STEVE H. MILES, *OATH BETRAYED: TORTURE, MEDICAL COMPLICITY AND THE WAR ON TERROR* 43–67 (2006).

¹⁴ See, e.g., Bloche & Marks, *Doctors and Interrogators at Guantanamo Bay*, *supra* note 13. However, some mental health professionals were sent to Survival, Evasion, Resistance, and Escape (“SERE”) school where U.S. soldiers are trained to resist interrogation at the hands of enemy captors. See M. Gregg Bloche & Jonathan H. Marks, *Doing Unto Others as They Did Unto Us*, *N.Y. TIMES*, Nov. 14, 2005, at 21; see also Jonathan H. Marks, *Doctors of Interrogation*, 35 *HASTINGS CTR. REPORT* 17, 18 (2005)

ants”¹⁵—assigned to teams known colloquially as “Biscuits”¹⁶—and their input was deemed “essential” in both the design of interrogation strategies and the interpretation of intelligence at Guantánamo Bay.¹⁷ They advised interrogators how to ramp up interrogation stressors in order to overcome the apparent resistance of detainees to questioning.¹⁸ The kinds of stressors used at Guantánamo Bay are now common knowledge, having been the subject of numerous newspaper reports and internal U.S. Army (“Army”) investigations.¹⁹ They include sleep deprivation and manipulation, exposure to loud noise and temperature extremes, and the use of stress positions.²⁰ Some reports indicate that behavioral science personnel used information derived from detainees’ medical records as the basis for their advice.²¹ In one instance, for example, they advised interrogators to exploit a detainee’s fear of the dark.²² Army documents also record that behavioral scientists were “on hand” to monitor interrogations, and that they were supposedly given the power to intervene if interrogations got out of hand.²³

Although there is evidence that Biscuit personnel monitored interrogations both inside and outside the interrogation room²⁴—in the latter case through one-way mirrors—there is little evidence that they intervened to prevent interrogations from going too far. On the contrary, Army documents suggest that behavioral science personnel (as well as some caregivers) stood by while detainees were abused. Mohammed Al Qahtani, the so-called “20th hijacker,”²⁵ was exposed

(discussing whether health professionals were employed for their professional expertise or in order to add an imprimatur of decency to the process).

¹⁵ Bloche & Marks, *Doing Unto Others as They Did Unto Us*, *supra* note 14.

¹⁶ Marks, *supra* 14, at 17 (discussing whether health professionals were employed for their professional expertise or in order to add an imprimatur of decency to the process).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.* at 17–22.

²⁰ See, e.g., PHYSICIANS FOR HUMAN RIGHTS, BREAK THEM DOWN: SYSTEMATIC USE OF PSYCHOLOGICAL TORTURE BY US FORCES (2005), available at <http://www.physiciansforhumanrights.org/library/documents/reports/break-them-down-the.pdf>.

²¹ Neil Lewis, *Interrogators Cite Doctors’ Aid at Guantanamo Prison Camp*, N.Y. TIMES, June 24, 2005, available at <http://www.nytimes.com/2005/06/24/politics/24gitmo.html?ex=1277265600&en=b1960558c2ad9fa4&ei=5088&partner=rssnyt&emc=rss>.

²² *Id.*

²³ Marks, *Doctors of Interrogation*, *supra* note 14, at 18.

²⁴ *Id.* at 17.

²⁵ He was not, of course, the only Al Qaeda suspect to be branded “the 20th hijacker.” See, e.g., Seymour M. Hersh, *The Twentieth Man: Has the Justice Department*

to an aggressive interrogation regime at Guantánamo Bay for up to twenty hours per day for forty-eight days over a fifty-four day period at the end of 2002 and beginning of 2003.²⁶ The interrogation log—obtained by *Time Magazine*—records the presence of a psychologist during parts of the interrogation.²⁷ However, the process still spiraled out of control, putting Al Qahtani's health in grave danger. On one occasion, Al Qahtani's pulse dropped to thirty-five beats per minute, and on two occasions his temperature dropped to ninety-five degrees.²⁸ To add insult to injury, when Al Qahtani was re-hydrated with three bags of intravenous fluids, interrogators refused to let him take a bathroom break, and he had no option but to wet himself.²⁹

This is not the only example of medical treatment or its sequelae being deployed for strategic purposes. Force-feeding of hunger strikers at Guantanamo Bay is being conducted with the assistance of medical personnel who are caregivers, not adjuncts to the interrogation mission.³⁰ After some U.S. Navy physicians refused to force-feed detainees, the Department of Defense began screening doctors assigned to Guantanamo Bay to ensure they would be willing to participate.³¹ The practice of force-feeding has been defended by the Pentagon as being necessary to protect the health of detainees.³² However, there are a number of reasons to doubt this claim. First, reports indicate that, in contrast with its use in federal prisons, force-feeding is being administered long before the health of detainees is

Mishandled the Case against Zacarias Moussaoui?, NEW YORKER, Sept. 30, 2002, available at http://www.newyorker.com/fact/content/articles/020930fa_fact.

²⁶ ARMY REG. 15-6: FINAL REPORT, INVESTIGATION INTO FBI ALLEGATIONS OF DETAINEE ABUSE AT GUANTANAMO BAY, CUBA DETENTION FACILITY (*as amended* June 9, 2005), 13–21, available at <http://www.defenselink.mil/news/Jul2005/d20050714report.pdf>.

²⁷ See Adam Zagorin & Michael Duffy, *Inside the Interrogation of Detainee 063*, TIME, June 12, 2005, available at <http://www.time.com/time/magazine/printout/0,8816,1071284,00.html>; see also INTERROGATION LOG DETAINEE 063, Nov. 23, 2002, <http://www.time.com/time/2006/log/log.pdf> (presenting a partially-redacted copy of the interrogation log); see also Steve Miles, *Medical Ethics and the Interrogation of Detainee 063*, 7 AM. J. BIOETHICS 3, available at http://www.bioethics.net/journal/j_articles.php?aid=1140 (discussing this interrogation from a medical ethics perspective).

²⁸ See Zagorin & Duffy, *supra* note 27.

²⁹ *Id.*

³⁰ Susan Okie, *Glimpses of Guantanamo-Medical Ethics and the War on Terror*, 353 *New Eng. J. Med.* 2529, 2530 (2006).

³¹ *Id.*

³² Luke Mitchell, *God Mode*, HARPER'S MAGAZINE, July 2006, available at <http://www.harpers.org/GodMode.html> (Aug. 24, 2006).

seriously threatened by their hunger strike.³³ Second, detainees have reportedly been forced to sit in their own urine and feces while strapped into a chair for “postfeed observation.”³⁴ Third, the Pentagon regards hunger strikes and suicide attempts as acts of “asymmetric warfare,”³⁵ rather than signs of desperation on the part of those being detained for an indefinite period on grounds that are often still unclear.³⁶ This view undermines the claim by the Assistant Secretary of Defense for Health Affairs, William Winkenwerder, Jr., M.D., that the Pentagon’s “intentions are good” and that they are “seeking to preserve life.”³⁷ How can the policy of force-feeding be *both* ethically responsible medical treatment and a response tactic in asymmetric warfare?

III. THE EVOLUTION (OR REVOLUTION) OF LEGAL DOCTRINE

In order to pave the way for the use of more aggressive interrogation techniques against so-called “high-value detainees” such as Al Qahtani, the Administration recognized that a number of legal hurdles needed to be addressed. As a result, they embarked on what I have described elsewhere as a series of exercises in legal exceptionalism, in which legal protections and prohibitions were dispensed with on the grounds that they were geographically limited (*spatial exceptionalism*), that they did not apply to a particular group (*collective exceptionalism*), or that their true meaning had been hitherto misunderstood (*interpretive exceptionalism*).³⁸ For present purposes, I will focus on just three examples, but there are many more.

First and foremost, the Administration wanted to make sure that interrogators deploying these techniques would not incur criminal

³³ George Annas, *Hunger Strikes at Guantanamo—Medical Ethics and Human Rights in a “Legal Black Hole,”* 355 *NEW ENG. J. MED.* 1377, 1379–80 (2006).

³⁴ *Id.* at 1377; Nancy Sherman, *Holding Doctors Responsible at Guantanamo*, 16 *KENNEDY INST. OF ETHICS J.* 199, 201 (2006).

³⁵ BBC News, *Guantanamo Suicides “Acts of War,”* June 11, 2006, <http://news.bbc.co.uk/2/hi/americas/5068606.stm>.

³⁶ Mark Denbeaux et al., *No-Hearing Hearings—CSRT: The Modern Habeas Corpus? An Analysis of the Proceedings of the Government’s Combatant Status Review Tribunals at Guantanamo*, Nov. 2005, http://law.shu.edu/news/final_no_hearing_hearings_report.pdf (finding Department of Defense documents indicate that “[t]he Government did not produce any witnesses in any [Combatant Status Review Tribunal] hearing and did not present any documentary evidence to the detainee prior to the hearing in 96% of the cases”).

³⁷ Mitchell, *supra* note 32.

³⁸ See Jonathan H. Marks, *9/11 + 3/11 + 7/7 = ? What Counts in Counterterrorism?*, 37 *COLUM. HUM. RTS. L. REV.* 559, 578–83 (2006).

responsibility for torture. This objective led to the August 2002 memorandum from then-Assistant Attorney General Jay Bybee to then-White House Counsel Alberto Gonzalez, entitled *Re: Standards of Conduct for Interrogation under 18 U.S.C. 2340–2340A*.³⁹ The document narrowly defined physical torture to require pain “equivalent in intensity to the pain accompanying serious physical injury, such as organ failure, the permanent impairment of a significant bodily function, or even death.”⁴⁰ For pain or suffering to rise to the level of mental torture, the memo added, “it must result in significant psychological harm of significant duration, e.g. lasting for months or even years.”⁴¹ Even if these thresholds are crossed and the interrogator *knows* they are being crossed, the memo contends that the interrogator would not be guilty of torture under U.S. criminal law “if causing such harm is not his objective.”⁴² Nor would he have committed torture, according to the memo, if he “could show that he acted in good faith by taking steps such as surveying professional literature, *consulting with experts*, or reviewing evidence gained from past experience.”⁴³ On the view set out in this memo—which was not revoked and replaced by the Department of Justice until after photographs of detainee abuse at Abu Ghraib had been published⁴⁴—the advice of behavioral science experts would be critical, at the very least, in order to insulate interrogators from domestic criminal liability.⁴⁵

³⁹ Memorandum from Jay S. Bybee, Assistant Att’y Gen., U.S. Dep’t of Justice, to Alberto R. Gonzales, White House Counsel, *Re: Standards of Conduct for Interrogation under 18 U.S.C. §§ 2340–2340A* (Aug. 1, 2002), *available at* <http://www.washingtonpost.com/wp-srv/nation/documents/dojinterrogationmemo20020801.pdf> [hereinafter Bybee Memo]. Sections 2340–2340A, which define the criminal offense of torture in the United States, were enacted in order to comply with the United States’ obligations under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984). See H.R. Rep. No. 103-482, at 229 (1994) (Conf. Rep.). The drafters of the Bybee memo drew on (and were admittedly facilitated by) understandings made by the United States when it ratified the Convention in 1994. See Sanford Levinson, “Precommitment” and “Post-commitment”: *The Ban on Torture in the Wake of September 11*, 81 TEX. L. REV. 2036–38 (2003). The text of the ratification instrument is available at <http://www.unhchr.ch/html/menu2/6/cat/treaties/convention-reserv.htm>.

⁴⁰ Bybee Memo, *supra* note 39, at 1.

⁴¹ *Id.*

⁴² *Id.* at 4.

⁴³ *Id.* at 8 (emphasis added).

⁴⁴ Although the document was revoked in June 2004, it was not formally replaced until December 2004, just days before the confirmation hearings of Attorney General Alberto Gonzales. See Memorandum from Daniel Levin, Acting Assistant Attorney General to James B. Comey, Deputy Attorney General, *Re: Legal Standards Applicable under 18 U.S.C. §§ 2340–2340A* (Dec. 30, 2004), *available at* <http://www.usdoj.gov/olc/dagmemo.pdf>.

⁴⁵ See Bybee Memo, *supra* note 39, at 8.

Having tried to narrow the definition of torture, the Administration continued to emphasize that the United States does not torture.⁴⁶ However, that still left the prohibition on CID treatment or punishment as a potential impediment to more aggressive interrogation strategies. As a party to both the ICCPR⁴⁷ and the Torture Convention,⁴⁸ the United States has committed itself to the prohibition against CID treatment, as well as torture. The ICCPR clearly states that this is an obligation to which no exception is permitted,⁴⁹ and the Torture Convention imposes an obligation on parties to review interrogation rules to ensure that they do not result in CID treatment.⁵⁰ When the United States ratified both treaties, it made reservations defining CID to mean cruel and unusual treatment or punishment prohibited by the Fifth, Eighth, and Fourteenth Amendments to the United States Constitution.⁵¹ The Bush Administration took the view that these reservations served not only to redefine the type of conduct that would be considered CID, but also operated to limit the geographic scope of the United States' international obligations so that they did not apply to aliens detained outside the United States.⁵² This view created, in effect, a "legal black hole" into which Guantanamo Bay, nominally leased by the United States from Cuba, conveniently appeared to fall.⁵³ This was the position which Senator John McCain sought to address in the so-called "McCain Amendment," now section 1003 of the Detainee Treatment

⁴⁶ See, e.g., Statement by the President on United Nations International Day in Support of Victims of Torture, <http://www.whitehouse.gov/news/releases/2003/06/20030626-3.html> (June 23, 2003) (stating that the "United States is committed to the world-wide elimination of torture and we are leading this fight by example").

⁴⁷ ICCPR, *supra* note 1.

⁴⁸ Torture Convention, *supra* note 2.

⁴⁹ For an authoritative interpretation of the ICCPR on this point, see Human Rights Committee, General Comment No. 20 (1992), ¶ 3, *available at* [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/6924291970754969c12563ed004c8ae5?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/6924291970754969c12563ed004c8ae5?OpenDocument) (last visited Feb. 5, 2007).

⁵⁰ Torture Convention, *supra* 2, arts. 11 & 16.

⁵¹ For the text of the United States' ratification of the Torture Convention, see 36 CONG. REC. S10091 (1990), *available at* <http://www.unhchr.ch/html/menu2/6/cat/treaties/convention-reserv.htm>. For the text of the United States' ratification of the ICCPR, see http://www.unhchr.ch/html/menu3/b/treaty5_asp.htm (last visited Nov. 25, 2006).

⁵² See Gonzales Nomination Transcript, *available at* http://www.humanrightsfirst.com/us_law/etn/gonzales/statements/gonz_testimony_010604.htm (last visited Mar. 30, 2006).

⁵³ See Johan Steyn, *Guantanamo Bay: The Legal Black Hole*, 53 INT'L & COMP. L.Q. 1-15 (2004).

Act of 2005.⁵⁴ Its provisions were intended to make clear that the prohibition of CID treatment applies irrespective of the nationality and geographic location of the detainee.⁵⁵ But when President Bush signed the Detainee Treatment Act into law, he issued a presidential signing statement declaring that the Administration would interpret the detainee provisions “in a manner consistent with the constitutional authority of the President to supervise the unitary executive branch and as Commander in Chief and consistent with the constitutional limitations on judicial power.”⁵⁶ This firm assertion of presidential power naturally raised serious doubts about the practical impact of the legislation on the Administration’s detention and interrogation policy.⁵⁷

Another important doctrinal reformulation—or exercise in legal exceptionalism—concerns the Geneva Conventions. Common Article Three of the Geneva Conventions provides protections that have long been understood as the low watermark for treatment of detainees, irrespective of their status.⁵⁸ Although so-called unlawful combatants are not entitled to the full array of protections applicable to prisoners of war, they are to be protected from cruel, humiliating, or degrading treatment *and* from outrages on personal dignity.⁵⁹ They are also to be treated humanely.⁶⁰ The formal position of the Ad-

⁵⁴ See Detainee Treatment Act of 2005, Pub. L. No. 109-48, § 1003, 119 Stat. 2680, 2739–2744 (2005).

⁵⁵ See *id.*

⁵⁶ Statement of President George W. Bush Upon Signing of H.R. 2863, Dec. 30, 2005, available at <http://www.whitehouse.gov/releaseas/2005/12/10551230-8.html>; see also T.J. Halstead, Cong. Res. Serv., *Presidential Signing Statements: Constitutional and Institutional Implications*, Sept. 20, 2006, available at <http://www.fas.org/sgp/crs/natsec/RL33667.pdf> (analyzing the impact of signing statements).

⁵⁷ It should be noted that a provision similar to the McCain Amendment also appears in the Military Commissions Act of 2006, Pub. L. No. 109-366, 120 Stat. 2600. However, the Military Commissions Act is problematic for several other reasons, some of which are discussed below. See notes 65–69 and accompanying text; see also Human Rights Watch, Q and A: Military Commissions Act of 2006, available at <http://hrw.org/backgrounder/usa/qna1006/usqna1006web.pdf> (briefly analyzing and critiquing the Military Commissions Act) [hereinafter Human Rights Watch].

⁵⁸ See, e.g., International Committee for the Red Cross, *Commentary on Geneva Convention III, Article 3*, <http://www.icrc.org/ihl.nsf/COM/375-590006?OpenDocument> (last visited Mar. 14, 2007); Michael John Garcia, Cong. Res. Serv., *The War Crimes Act: Current Issues*, Oct. 2, 2006, available at <http://www.fas.org/sgp/crs/intel/RL33662.pdf>; see also Ruth Wedgwood & R. James Woolsey, *Law and Torture*, WALL ST. J., June 28, 2004, at A10.

⁵⁹ Third Geneva Convention, *supra* note 9, art. 3.

⁶⁰ *Id.* A similar obligation is found in Article 10 of the ICCPR, which provides that “[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.” ICCPR, *supra* note 1, art. 10.

ministration, determined in February 2002, was that the Geneva Conventions did not apply to detainees who are members of Al Qaeda, because Al Qaeda is neither a state nor a party to the Conventions.⁶¹ However, that position was unequivocally rejected by the Supreme Court of the United States in *Hamdan v. Rumsfeld* in June 2006.⁶² The Department of Defense responded to this decision with a memorandum calling for a review of directives and policies to ensure compliance with Common Article Three.⁶³ But just a few weeks later, in September 2006, the President publicly criticized the provisions of Common Article Three for being too vague.⁶⁴ Congress addressed the President's concerns later that month, passing the Military Commissions Act of 2006 ("MCA").⁶⁵ The MCA purports to confer on the President the authority to "interpret the meaning and application of the Geneva Conventions."⁶⁶ It remains to be seen how the President will respond to this provision. But there is a real danger that the Executive will view it as providing *carte blanche* to define Article Three's protections narrowly. Although the MCA states that "[n]othing in this section shall be construed to affect the constitutional functions and responsibilities of . . . the judicial branch of the United States,"⁶⁷ this provides little comfort given the MCA's attempts to strip the federal courts of habeas corpus jurisdiction over detainees,⁶⁸ and to pre-

⁶¹ Office of the White House Press Secretary, Fact Sheet: Status of the Detainees at Guantanamo, Feb. 7, 2002, <http://www.whitehouse.gov/news/releases/2002/02/20020207-13.html>.

⁶² *Hamdan v. Rumsfeld*, 126 S. Ct. 2749, 2794–95 (2006).

⁶³ Memorandum from Gordon England, Deputy Secretary of Defense to the Secretaries of the Military Departments et al., Application of Common Article 3 of the Geneva Conventions to the Treatment of Detainees in the Department of Defense (July 7, 2006), available at <http://www.defenselink.mil/news/Aug2006/d20060814comm3.pdf>.

⁶⁴ The President acknowledged that the "Supreme Court's ruling [in *Hamdan*] . . . said that we must conduct ourselves under the Common Article 3 of the Geneva Convention." He added: "And that Common Article 3 says that there will be no outrages upon human dignity. It's very vague. What does that mean, 'outrages upon human dignity?' That's a statement that is wide open to interpretation." Transcript of Sept. 15, 2006, Press Conference of the President, available at <http://www.whitehouse.gov/news/releases/2006/09/20060915-2.html>.

⁶⁵ Military Commissions Act of 2006, Pub. L. No. 109-366, 120 Stat. 2600.

⁶⁶ *Id.* § 6(a)(3)(A).

⁶⁷ *Id.*

⁶⁸ *Id.* § 7. See also Gerald L. Neuman, *The Military Commissions Act and the Detainee Debacle: A Response*, 48 HARV. INT'L L.J. ONLINE 33 (2007), <http://www.harvardilj.org/online/105> (arguing that Congress did not have the power to permanently abrogate the writ of habeas corpus) and Robert M. Chesney, *Judicial Review, Combatant Status Determinations, and the Possible Consequences of Boumediene*, 48 HARV. INT'L L.J. ONLINE 62 (2007), <http://www.harvardilj.org/online/110> (observing that the "slowly grind-

vent them from invoking the Geneva Conventions “as a source of rights” in domestic litigation.⁶⁹ If the President does narrowly redefine the scope of protections in the Geneva Conventions, it is therefore likely to be some time before a federal court will be given the opportunity to correct this. That delay will be too long, not just for detainees at Guantánamo Bay and elsewhere, but also for health professionals with whom they have contact.

Whatever the Administration’s interpretation of the Geneva Conventions, health professionals would be well-advised to remember that international legal norms—as commonly understood by other nations and, in the case of the Geneva Conventions, as authoritatively interpreted by the International Committee of the Red Cross (“ICRC”)⁷⁰—will be violated by more aggressive interrogation strategies long before the mental and physical health or well-being of detainees are implicated. For example, the prohibition of outrages on personal dignity in Common Article Three was clearly breached by soldiers who placed underwear on the heads of detainees or forced them to assemble naked in pyramid formation.⁷¹ Second, medical personnel may be complicit in the commission of grave breaches of the Geneva Conventions—also known as war crimes—if they advise on or monitor the use of interrogation tactics that qualify as torture or inhuman treatment or that “willfully cause great suffering.”⁷² War crimes attract universal jurisdiction.⁷³ So even if health professionals

ing process of developing and stabilizing our detainee laws and policies unfortunately is not yet near its conclusion”).

⁶⁹ *Id.* at § 5. In particular, this section seeks to prevent the Geneva Conventions from being invoked as a source of rights in habeas corpus or other civil proceedings against the United States, and any of its current or former officers, employees, or agents. *Id.*

⁷⁰ INT’L COMM. OF THE RED CROSS, INTERNATIONAL HUMANITARIAN LAW—TREATIES OF DOCUMENTS 1 (2005), <http://www.icrc.org/ihl.nsf/CONVPRES?OpenView> (ICRC’s authoritative commentary on the Geneva Conventions).

⁷¹ BG FURLOW & LT. GEN. SCHMIDT, INVESTIGATION INTO FBI ALLEGATIONS OF DETAINEE ABUSE AT GUANTANAMO BAY, CUBA DETENTION FACILITY 19 (June 9, 2005) (indicating that Guantánamo Bay detainee, Al Qahtani, “was forced to wear a woman’s bra and had a thong placed on his head during interrogation”). For the infamous image of a human pyramid at Abu Ghraib, which has become emblematic of detainee abuse in the war on terror, see *New Yorker*, at http://www.newyorker.com/online/slideshows/slideshows/040510onslpo_prison_02 (last visited Feb. 10, 2007).

⁷² See Third Geneva Convention, *supra* note 9, art. 130, available at <http://www.unhchr.ch/html/menu3/b/91.htm>; for a discussion of the War Crimes Act in the United States, see also Garcia, *supra* note 58.

⁷³ For a more detailed discussion of universal jurisdiction and its theoretical foundations, see Jonathan H. Marks, *Mending the Web: Universal Jurisdiction, Humani-*

were not concerned about potential prosecution in the United States,⁷⁴ they would be ill-advised to ignore the possibility of being arrested and tried while visiting another country.

IV. LAW AND MEDICAL ETHICS

In the face of the Administration's efforts to circumvent international legal protections for detainees in the war on terror, the voice of professional ethics is especially important. Professional ethics should not be an entirely autonomous enterprise. In particular, ethical codes for physicians, psychologists, and other health care professionals should incorporate basic standards that reflect fundamental protections found in international human rights law and the laws of war.⁷⁵ The Report of the American Psychological Association's Task Force on Psychological Ethics and National Security in July 2005 notably failed to do this. Proscriptions against psychologists' participation in abusive interrogation were not defined by reference to international law. They were merely tied to "applicable" U.S. rules and regulations as "developed and refined" since 9/11.⁷⁶ When one recalls the administration's efforts to "refine" legal norms, the dangers inherent in this approach are manifest. The report also fails to recognize that since the vast majority of detainees in the war on terror are foreign nationals, the propriety of their treatment is far more likely to be judged by international standards than by domestic ones, particularly if the latter are more lax.

tarian Intervention and the Abrogation of Immunity by the Security Council, 42 COLUM. J. TRANSNAT'L L. 445 (2004).

⁷⁴ The Military Commissions Act also amends the War Crimes Act. Military Commissions Act of 2006, Pub. L. No. 109-366, 120 Stat. 2600. For a brief summary of the material revisions, see Human Rights Watch, *supra* note 57.

⁷⁵ See Leslie London et al., *Dual Loyalty Among Military Health Professionals*, 15 CAMBRIDGE Q. OF HEALTHCARE ETHICS 381, 385-86 (2006) (discussing the value of a human rights perspective). In the remainder of this section, I will argue that human rights should be the foundation of a health professional's ethical obligations, but not the limit of those obligations.

⁷⁶ REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY (2005), available at <http://www.apa.org/releases/PENSTaskForceReportFinal.pdf> [hereinafter PRESIDENTIAL TASK FORCE]; see also Tara McKelvey, *First Do Some Harm*, AMERICAN PROSPECT, Sept. 1 2005, <http://www.prospect.org/web/printfriendly-view.wv?id=10110> (critiquing the task force, many of whose members had military or national security affiliations); Michael Benjamin, *Psychological Warfare*, SALON.COM, July 26, 2006, <http://www.salon.com/news/feature/2006/07/26/interrogation/index.html>; Mark Benjamin, *Psychologists' Group Still Rocked by Torture Debate*, SALON.COM, Aug. 4, 2006, <http://www.salon.com/news/feature/2006/08/04/apa/>.

It is possible simply to tie ethical constraints on health professionals to international legal prohibitions—an approach taken in the United Nations Principles of Medical Ethics.⁷⁷ For example, physicians are prohibited from using their knowledge and skills to assist in an interrogation that adversely affects the health or condition of a detainee *and* is “not in accordance with the relevant international instruments.”⁷⁸ These instruments would obviously include the Geneva Conventions, the ICCPR, and the Torture Convention. But giving legal norms the last word on the limits of professional conduct leaves psychiatrists and psychologists without clear guidance in the face of disagreements between lawyers and policymakers about the application of those norms. The efforts to redefine the scope and meaning of the Geneva Conventions and the prohibition of CID treatment in core human rights treaties—discussed above—provide two powerful illustrations of this point.⁷⁹

Some codes of professional ethics impose firm constraints on health professionals, irrespective of the applicable legal norms. For example, the World Medical Association’s Regulations in Times of Armed Conflict state that it is unethical for physicians to “[w]eaken the physical or mental strength of a human being without therapeutic justification” or to “[e]mploy scientific knowledge to imperil health.”⁸⁰ It is difficult to understand how a physician with these prohibitions in mind would have felt able to participate in the kinds of aggressive interrogation stressors deployed at Guantánamo Bay. At the very least, the express purpose of coercive counter-resistance tactics such as prolonged isolation and sleep deprivation was to weaken

⁷⁷ Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 37/194, Annex, U.N. Doc. A/RES/37/194 (Dec. 18, 1982), *available at* <http://www.un.org/documents/ga/res/37/a37r194.htm>.

⁷⁸ *Id.* at princ. 4.

⁷⁹ *See supra* Part III.

⁸⁰ WORLD MEDICAL ASSOCIATION, REGULATIONS IN TIMES OF ARMED CONFLICT ¶ 2 (2006), *available at* <http://www.wma.net/e/policy/a20.htm> [hereinafter REGULATION IN TIMES OF ARMED CONFLICT]. These provisions were in effect in 2002 when the aggressive interrogation strategies were introduced at Guantánamo Bay. *See* Amnesty International, Ethics Codes and Declarations Relevant to the Health Professions, ACT 75/05/00, at 18 (4th ed., 2000). Following the revelations of physician participation in interrogation in the war on terror, two more instances of unethical behavior were added to the list in May 2006. The regulations now state that it is also unethical for a physician to “[e]mploy personal health information to facilitate interrogation[,]” or to “[c]ondone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.” REGULATION IN TIMES OF ARMED CONFLICT, *supra*, at ¶2(d) and (e). The latter, in particular, should already have been obvious.

the mental and physical strength of detainees.⁸¹ In light of this, the American Medical Association (“AMA”) might have been expected to respond clearly and speedily to revelations of the involvement of American physicians in aggressive interrogations.

However, the AMA did not formally take a position on the role of physicians in interrogation until the summer of 2006.⁸² The new ethical guidelines provide that “[p]hysicians must neither conduct nor directly participate in, or monitor an interrogation, because a role as physician-interrogator undermines the physician’s role as healer.”⁸³ However, physicians are permitted to participate in “developing effective interrogation strategies for general training purposes,” provided those strategies are humane and respectful of individuals’ rights, and do not “threaten or cause physical injury or mental suffering.”⁸⁴ The American Psychiatric Association adopted a similar position in May 2006, prohibiting psychiatrists from “direct participation” in interrogation, defined to include “being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with

⁸¹ See Bloche & Marks, *Doing Unto Others as They Did Unto Us*, *supra* note 14 (discussing the source of the aggressive interrogation strategies deployed at Guantánamo Bay).

⁸² See Jonathan H. Marks, *The Silence of the Doctors*, THE NATION, Dec. 26, 2005, available at www.thenation.com/docpremm.html?i=20051226&5=marks (critiquing the AMA’s failure to speak out sooner).

⁸³ AM. MED. ASS’N, OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: PHYSICIAN PARTICIPATION IN INTERROGATION (2006), available at <http://www.ama-assn.org/ama1/pub/upload/mm/475/cejo4i06.doc>. This followed the revision to the World Medical Association’s Declaration of Tokyo (Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment) in May 2006 to provide that “[t]he physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.” The revised Declaration is available at <http://www.wma.net/e/policy/c18.htm>.

⁸⁴ AM. MED. ASS’N, *supra* note 83. In a press release, the Chair of the AMA’s Council on Ethical and Judicial Affairs, Priscilla Ray, M.D., stated that because “it is justifiable for physicians to serve in roles that serve the public interest,” the “AMA policy permits physicians to develop general interrogation strategies that are not coercive, but are humane and respect the rights of individuals.” See Press Release, AMA, New AMA Ethical Policy Opposes Direct Physician Participation in Interrogation (Jun. 12, 2006), <http://www.ama-assn.org/ama/pub/category/16446.html>. Neither the policy statement nor the press release addresses the question of whether physicians would ordinarily possess the expertise to advise on what interrogation techniques might generally be effective. For a discussion of potential rationales for seeking medical advice on interrogation, see Marks, *Doctors of Interrogation*, *supra* note 14.

particular detainees.”⁸⁵ The psychiatrists’ association also permits its members to provide training to interrogators on “recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.”⁸⁶

Although the guidelines of both the AMA and the American Psychiatric Association therefore leave open the possibility of giving general advice and training to military and civilian personnel in either law enforcement or intelligence branches, they make clear that physicians should stay out of the interrogation room—and, for that matter, any adjoining observation room—and that they should not give advice on specific interrogation techniques for specific detainees. By contrast, the August 2006 resolution of the American Psychological Association cleared the way for continued participation of psychologists in individual interrogations at Guantánamo Bay.

That resolution admittedly improves on the organization’s 2005 task force report by providing that “psychologists shall work in accordance with international human rights instruments relevant to their roles.”⁸⁷ However, the remainder of the document simply ties the prohibitions on psychologists’ conduct to the basic legal prohibitions on torture and CID treatment. Thus, psychologists must not “knowingly engage in, tolerate, direct, support, advise, or offer training” in such treatment.⁸⁸ Nor shall they “provide knowingly any research, instruments, or knowledge that facilitates” such treatment.⁸⁹ Nor shall they “knowingly participate in any procedure in which [such treatment] is used or threatened.”⁹⁰ And should they be present when torture or CID treatment occurs, they should try to stop the abuse and “failing that, exit the procedure.”⁹¹ In essence, these regulations re-

⁸⁵ Am. Psychiatric Ass’n, *Psychiatric Participation in Interrogation of Detainees: Position Statement (2006)*, available at http://www.psych.org/edu/other_res/lib_archives/archives/200601.pdf.

⁸⁶ *Id.*

⁸⁷ Compare Am. Psychol. Ass’n, *Resolution Against Torture and Cruel, Inhuman, and Degrading Treatment or Punishment (Aug. 9, 2006)*, available at <http://www.apa.org/governance/resolutions/notortureres.html> [hereinafter *Resolution Against Torture*], with PRESIDENTIAL TASK FORCE, *supra* note 76 (the former incorporating human rights standards in the manner described in the text accompanying this note, the latter stating that the Task Force “did not reach consensus on . . . [t]he role of human rights standards in an ethics code”).

⁸⁸ *Resolution Against Torture, supra* note 87.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

quire psychologists to obey the laws that bind us all. Beyond that, psychologists have only their consciences as a guide.

The egregious abuse of detainees at Guantánamo Bay (and elsewhere) raises real concerns about the role of psychologists in military interrogations, and emphasizes the need for firmer guidance. Dr. Koocher, President of the American Psychological Association in 2006, claims that psychologists are best placed to detect and prevent “behavioral drift” on the part of interrogators—that is, the slide into unprofessional and ultimately illegal behavior.⁹² But he fails to recognize that there are powerful social and institutional pressures on health professionals associated with the intelligence mission, including military psychologists, that weigh heavily against intervening—pressures that may well have been responsible for the Biscuit psychologist’s failure to intervene in the aggressive interrogation of Al Qahtani.⁹³

Put simply, interrogators are not the only people subject to “behavioral drift”—it may equally affect the psychologists charged with identifying and preventing it.⁹⁴ Furthermore, the American Psychological Association’s new guidelines create the additional problem of what I call *definitional drift*. By tying the principal constraints on psychologists’ conduct to the prohibition on torture and CID treatment, the American Psychological Association’s summer 2006 resolution leaves psychologists vulnerable to drifting definitions, in particular the Administration’s efforts to redefine those norms. This vulnerability is particularly important in light of the Administration’s emerging preference for staffing Biscuits with psychologists rather than psychiatrists⁹⁵—a preference that predates, but has been reinforced by,

⁹² Gerald P. Koocher, *Varied and Valued Roles*, MONITOR ON PSYCHOL., July-Aug. 2006, at 5, available at <http://www.apa.org/monitor/julaug06/pc.html>. The same claim was made by the Director of the American Psychological Association’s Ethics Office in Stephen Behnke, *Ethics and Interrogations: Comparing and Contrasting the American Psychological, American Medical and American Psychiatric Association Positions*, MONITOR ON PSYCHOL., July-Aug. 2006, at 66, available at <http://www.apa.org/monitor/julaug06/interrogations.html>.

⁹³ The psychologist referred to here is discussed in the text accompanying note 27 above. See also Marks, *Doctors of Interrogation*, *supra* note 14.

⁹⁴ Ironically, one of the members of the APA’s PRESIDENTIAL TASK FORCE has argued that its report (*see* note 76, *supra*) was itself the result of behavioral drift. Telephone interview with Jean Maria Arrigo, Ph.D, Founder, Project on Ethics and Art in Testimony, in Irvine, Cal. (Dec. 1, 2006).

⁹⁵ DEP’T OF DEFENSE INSTRUCTION NO. 2310.08E, MEDICAL PROGRAM SUPPORT FOR DETAINEE OPERATIONS (2006), available at http://www.fas.org/irp/doddir/dod/i2310_08.pdf. “[P]hysicians are not ordinarily assigned duties as [behavioral science consultants], but may be so assigned, with the approval of [the Assistant Secretary of Defense for Health Affairs], in circumstances when qualified psychologists are un-

the new professional guidelines for physicians in general, and psychiatrists in particular.⁹⁶

V. CONCLUSION

The involvement of health professionals in interrogation is hardly new. To give just one example, congressional testimony describes the role of an American physician in a form of torture known as the “water cure” in the war in the Philippines more than a hundred years ago.⁹⁷ There too, the victims of aggressive interrogation and torture were considered undeserving of the protections of the laws of war—a precedent for current exceptionalism expressly justified on grounds that enemy “insurgents” were “not civilized.”⁹⁸ However, the systematic involvement of mental health professionals in U.S. Army interrogation practice was a significant development. Writing some months before this development occurred, M. Gregg Bloche—who trained as both a lawyer and a physician—observed that the “unreflective willingness of most Western physicians to employ clinical skills for myriad state purposes suggests that their ethical sensitivity to the problem of extraclinical consequences does not greatly exceed that of their colleagues in countries where gross human rights abuse is endemic.”⁹⁹ Bearing this in mind, he emphasized the need for the training of health professionals in both ethics and interna-

able or unavailable to meet critical mission needs.” *Id.* at E2.2. This follows the recommendation of Maj. Gen. Martinez-Lopez in April 2005 that physicians should not be assigned to Biscuits. See OFFICE OF THE SURGEON GENERAL, ARMY, FINAL REPORT, ASSESSMENT OF DETAINEE MEDICAL OPERATIONS FOR OEF, GTMO, AND OIF (2005), available at http://www.globalsecurity.org/military/library/report/2005/detmedopsrpt_13apr2005.pdf.

⁹⁶ See Ken Hausman, *Military Looks to Psychologists for Advice on Interrogation*, PSYCHIATR. NEWS, July 7, 2006, at 4, available at <http://pn.psychiatryonline.org/cgi/content/full/41/13/4> (discussing a statement made by the Assistant Secretary of Defense for Health Affairs, William Winkenwerder, Jr., to the effect that the different stances adopted by the psychologists’ and psychiatrists’ professional associations “contributed” to the Pentagon’s preference for staffing Biscuits with psychologists).

⁹⁷ S. COMM. REC. ON THE PHILIPPINES, at 1527–32 (1899–1921) (testimony of Charles S. Riley), reprinted in HENRY F. GRAFF, AMERICAN IMPERIALISM AND THE PHILIPPINE INSURRECTION (1969) 72–80 and discussed in Marks, *The Silence of the Doctors*, *supra* note 82, at 26.

⁹⁸ S. COMM. REC. ON THE PHILIPPINES, at 558–64 (1899–1921) (testimony of Gen. Hughes) reprinted in HENRY F. GRAFF, *supra* note 97, 64–72; see also Marks, *What Counts*, *supra* note 38, at 579.

⁹⁹ M. Gregg Bloche, *Caretakers and Collaborators*, 10 CAMBRIDGE Q. HEALTHCARE ETHICS 275, 278 (2001). In a prescient note of caution, Bloche added that, if Western physicians lack the appropriate ethical sensitivity, “their ability to avert complicity when state purposes turn troublesome or worse would not likewise differ greatly from that of their peers in more problematic settings.” *Id.*

tional human rights norms, for institutional mechanisms to nurture professional autonomy, and for international support from (among others) professional bodies.¹⁰⁰

The importance of these recommendations is highlighted not only by revelations of health professionals' complicity in detainee abuse, but also by recent statements of an experienced U.S. interrogator in the war on terror. He notes that, in addition to the predictable pressure to support the military objectives of their colleagues, some health professionals may have financial anxieties too. In the interrogator's words:

Most of the PAs [physician assistants] or doctors that we use have been through medical school due to military scholarships. They owe the military big bucks. If they refused to aid us then they might be brought up on charges in an internal trial and would be forced to repay the military.¹⁰¹

I do not intend to suggest that military health professionals are venal. On the contrary, the vast majority pursue careers in the military—despite the call of more lucrative private practice—for noble and altruistic reasons. However, it would be foolish to pretend either that those financial pressures do not exist or that they cannot have an impact—even subconsciously—on an individual's moral calculus. Furthermore, if social and financial pressures are not sufficient to bring on board health professionals despite their ethical qualms, interrogators may use other means to procure their cooperation and compliance with the interrogation mission.

We already know that military personnel at Guantánamo Bay were manipulated. They were told that the detainees were “the worst of the worst.”¹⁰² According to Department of Defense documents, the vast majority had been handed over to U.S. forces by Pakistan or the Northern Alliance in exchange for large bounties—and most of them were not alleged to have committed any hostile acts against either the United States or its allies.¹⁰³ Health professionals, in particular, are

¹⁰⁰ *Id.* at 283.

¹⁰¹ The Arrigo Papers, *supra* note 12.

¹⁰² ERIK SAAR AND VIVECA NOVAK, *INSIDE THE WIRE: A MILITARY INTELLIGENCE SOLDIER'S EYEWITNESS ACCOUNT OF LIFE AT GUANTANAMO* 193 (2005).

¹⁰³ MARK DENBEAUX ET AL., *REPORT ON GUANTANAMO DETAINEES: A PROFILE OF 517 DETAINEES THROUGH ANALYSIS OF DEPARTMENT OF DEFENSE DATA 2-3* (2006), available at http://law.shu.edu/news/guantanamo_report_final_2_08_06.pdf. In addition, among the detainees were both children and the senescent. See Oliver Burkeman, *Children Held at Guantanamo*, *GUARDIAN*, Apr. 24, 2003, available at <http://www.guardian.co.uk/afghanistan/story/0,1284,942347,00.html>; Times Wire Reports, *Oldest Guantanamo Detainee Returns Home*, *L.A. TIMES*, Aug. 29, 2006, A8 (re-

not in a position to verify the provenance of a detainee. Nor do they have the knowledge or expertise to assess the security threat posed by a particular detainee.¹⁰⁴ So health professionals are in a position of ignorance and uncertainty that may be exploited. The interrogator quoted above has also indicated that intelligence personnel may lie to health professionals:

If the people are worried about doctors and psychologists aiding their own military in time of war, we can just have those who do work with us say we are not harming anyone. If they worry about our methods then we say that all plans of interrogation have approved the tactics as non 'stressful'. *As you can lie to a terrorist to get information then you can lie to any group that interferes with the job of making the people safe.*¹⁰⁵

The interrogator also noted that if the use of doctors or physician assistants becomes problematic (or "too much," in his words), interrogators "would then make use of our ParaRescue or Combat Medics for medical expertise in interrogations."¹⁰⁶ This is important since much of the discussion to date has been about the role of psychiatrists and psychologists in interrogation. Now that the AMA and the American Psychiatric Association have issued guidelines that seek to keep doctors out of the interrogation room—and empower them both legally and practically to refuse to participate¹⁰⁷—the spotlight has focused on psychologists.¹⁰⁸ But we would do well to remember that other types of health professionals may also be implicated.

The recent proliferation of Department of Defense manuals and directives—most notably, the new Army interrogation manual prohibiting the use of "waterboarding," hooding, and military dogs in interrogation¹⁰⁹—is presumably intended to suggest that the Administration is trying to redress the errors of the past. But it is not clear how these policy documents will play out on the ground. Arguably, they

porting that Haji Nasrat Khan, an Afghan detainee, who was "at least 71" and uses a walker, has been sent home).

¹⁰⁴ See London, *supra* note 75, at 386.

¹⁰⁵ The Arrigo Papers, *supra* note 12 (emphasis added).

¹⁰⁶ *Id.*

¹⁰⁷ International humanitarian law prohibits states from requiring medical professionals to act contrary to their codes of ethics. See Bloche & Marks, *Doctors and Interrogators at Guantanamo Bay*, *supra* note 14; Marks, *What Counts*, *supra* note 38, at 582.

¹⁰⁸ See, e.g., Michael Benjamin, *Psychological Warfare*, SALON.COM, July 26, 2006, <http://www.salon.com/news/feature/2006/07/26/interrogation/index.html>; Mark Benjamin, *Psychologists' Group Still Rocked by Torture Debate*, SALON.COM, Aug. 4, 2006, <http://www.salon.com/news/feature/2006/08/04/apa/>.

¹⁰⁹ See FM 2-22.3 (FM 34-52), HUMAN INTELLIGENCE COLLECTOR OPERATIONS ¶ 5-75 (2006), available at <http://www.fas.org/irp/doddir/army/fm2-22-3.pdf>.

may be of little relevance at the present time since detainees who have been held for years at Guantanamo Bay can no longer have actionable intelligence (even if they once did so), and there would be little point in interrogating them. However, fundamental questions remain about detainees held by the CIA, whatever their location. The CIA is contesting the ACLU's FOIA applications, so its practices are still shrouded in secrecy, and detainees in its custody will not benefit from the provisions of the new Army field manual.¹¹⁰ Furthermore, in a recent radio interview, Vice President Cheney was asked: "Would you agree a dunk in water is a no-brainer if it can save lives?"¹¹¹ Mr. Cheney replied: "It's a no-brainer for me."¹¹² In the same interview, he agreed that the debate over interrogation techniques was "a little silly."¹¹³ These comments reveal a failure at the highest levels of government to internalize the most fundamental norms of human rights law and the laws of war. In such an environment, health professionals should still be considered "at risk"—that is, in danger of becoming accomplices to the perpetration of war crimes in the counterterrorism mission. Looking forward, one of the most important questions is:

How will *they* respond?

¹¹⁰ Although current CIA interrogation guidelines are classified, previous CIA manuals have been made public. See, e.g., KUBARK COUNTERINTELLIGENCE INTERROGATION (1963), available at <http://www.gwu.edu/~nsarchiv/NSAEBB/NSAEBB27/01-01.htm>.

¹¹¹ See Demetri Sevastopulo, *Cheney Endorses Simulated Drowning: Says Use of Water Boarding to Get Terrorist Intelligence is "no brainer"*, FIN. TIMES (London), Oct. 26, 2006, available at <http://www.msnbc.msn.com/id/15433467/>; see also Dan Eggen, *Cheney Defends "Dunk in the Water" Remark Addressing Alarm Over the Comment, Vice President Says He Was Not Referring to Waterboarding*, WASH. POST, Oct. 28, 2006, at A02, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/10/27/AR2006102700560.html>.

¹¹² See Sevastopulo, *supra* note 111.

¹¹³ *Id.*