Coercive US Interrogation Policies
A Challenge to Medical Ethics

Leonard Rubenstein, JD
Christian Pross, MD
Frank Davidoff, MD
Vincent Iacopino, MD, PhD

As world attention has focused on allegations of torture and ill treatment (cruel, inhuman, and degrading treatment or punishment) by US forces, there have been questions about the role of physicians and other health professionals in abusive interrogations. Considerable light has been shed on these allegations by documents released in 2004 and 2005 under the Freedom of Information Act and official US Department of Defense (DoD) investigations initiated since the Abu Ghraib investigations in 2004, including an internal review of medical practices regarding detainees by the US Army surgeon general. Following the release of these documents and reports, in June 2005, the assistant secretary of defense for health affairs released new ethical guidelines for all health care personnel, including physicians, nurses, and medics. The new guidelines are troubling, however, because they do not come to terms with the participation of physicians and other health professionals in officially authorized interrogation practices that are absolutely prohibited by international human rights law, the Third Geneva Convention, and US military and domestic law that criminalizes torture, including psychological torture. While the new DoD ethical guidelines apply to all health care personnel, we focus on how the guidelines enable physicians to facilitate and monitor abusive interrogation practices and subvert well-established ethical duties to support health and human dignity.

International Ethical Standards for Physicians and Other Health Professionals

The role of physicians in coercive interrogation became a matter of concern during the 1970s following reports of physician participation in torture in Greece, Chile, and other countries and interest by the British government in using physicians with psychiatric training to monitor detainees subjected to harsh interrogations in the effort to stop terrorism in Northern Ireland. Complicity took many forms: examining individuals for “fitness” for torture, advising interrogators on effective techniques, observing and monitoring torture, and providing treatment to facilitate further torture. A British government commission supported the presence of physicians to observe interrogation as a safeguard against torture, but after reviewing the experiences of physicians in torture, the British Medical Association, and later, the World Medical Association (WMA), concluded that participation of physicians in designing, or even monitoring, interrogation strategies for the purpose of protecting the detainee was far more likely to exacerbate harms to detainees than to offer them safety. The British government adopted the British Medical Association’s position.

In 1975, the WMA promulgated ethical standards, later adopted by the American Medical Association, recommending that physicians follow the absolute rule against torture. The WMA’s Declaration of Tokyo established a clear ethical line: physicians can play no role whatsoever in torture or cruel, inhuman, or degrading treatment. That means they cannot participate in, use their knowledge or skills to facilitate, or condone torture or ill treatment, or be present when it does take place.

In 1982, the United Nations (UN) General Assembly addressed the ethical questions associated with participation of physicians (as well as other health personnel) in the interrogation of prisoners and detainees. It is important to note that while ethical codes developed by professional associations refer to specific practitioner groups, ethical principles developed by the UN and other bodies apply to all “health personnel, particularly physicians.” The UN 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 (referred to herein as the UN principles) state as an absolute rule that health personnel, particularly physicians, may not “engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment” and further illuminate the ethical obligations in the

Author Affiliations: Physicians for Human Rights, Cambridge, Mass (Mr Rubenstein and Dr Iacopino); Center for the Treatment of Torture Victims, Berlin, Germany (Dr Pross); Hamburg Foundation for the Advancement of Research and Culture, Hamburg, Germany (Dr Pross); editor emeritus of Annals of Internal Medicine, Philadelphia, Pa (Dr Davidoff); and Department of Medicine, University of Minnesota, Minneapolis (Dr Iacopino).

Corresponding Author: Leonard Rubenstein, JD, 1156 15th St NW, Washington, DC 20005 (lrubenstein@phrusa.org).
interrogation of prisoners and detainees. In particular, the UN principles hold that it is unethical for health personnel, particularly physicians, to engage in any professional relationships with detainees other than to evaluate, protect, or improve their physical and mental health. The UN principles also address acts considered complicity in torture and ill treatment by prohibiting physicians from either using their skills “in order to assist in interrogations” or “participating in the certification of the fitness of prisoners or detainees for any form of treatment” in a manner that would harm the health of detainees and violate international human rights instruments, such as those explicated in the Geneva Convention regarding prisoners of war\(^\text{10}\) or the Convention Against Torture.\(^\text{1}\)

**Ethical Guidelines Recently Issued by the US DoD**

The newly released US DoD guidelines, Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States\(^\text{8}\) (referred to herein as the DoD guidelines), purport to recognize the duty of “health care personnel, particularly physicians” to uphold humane treatment of detainees and follow some of the approaches and language from the UN principles.\(^\text{18}\) However, the DoD guidelines differ from the UN principles in several fundamental respects (TABLE). The DoD guidelines make no reference to torture and they may undermine a physician’s duty to provide humane treatment by (1) making a distinction between clinical and nonclinical activities, (2) linking ethical conduct to US interpretations of “applicable law” and disregarding the possible risk of infliction of harm and the violation of international standards, and (3) eliminating even a partial duty to protect medical confidentiality.

Under the DoD guidelines, the proscription against participation in any activity other than to evaluate, protect, or improve the physical and mental health of detainees applies only to health care personnel who are actively engaged in clinical treatment of detainees. A recent review of medical care of detainees ordered by the DoD and conducted by the office of the US Army surgeon general affirmed, pending further review, that psychiatrists and other physicians who do not provide clinical care can participate in the interrogation process.\(^\text{7}\) In the course of the Nuremberg doctor trials,\(^\text{19,20}\) there were attempts to justify harmful, but nonclinical activities, such as human experiments in the name of the exigencies of war. However, ethical codes developed after World War II make no such role distinction; rather, ethical obligations are premised on the basis of the physician’s scientific knowledge and understanding, the values of the profession, and the unique social and cultural place a physician occupies.\(^\text{4}\) The practical consequences of the distinction between clinical and nonclinical involvement of physicians in interrogation of detainees are important because such distinctions permit physician participation in the planning, implementation, and monitoring of interrogation.

The new DoD guidelines do admonish all health personnel, whatever their role, to uphold a duty of humane treatment of detainees. Yet, while the UN principles forbid participation by health personnel in torture or ill treatment or harmful interrogations in violation of international standards, the DoD guidelines allow physicians to “assist in the interrogation of detainees” and to participate in the certification of the fitness for treatment or punishment so long as it is in accordance with “applicable law.”\(^\text{19}\) As we discuss below, one of the hallmarks of current US interrogation policy has been reinterpretation of the Geneva Conventions,\(^\text{21}\) the Convention Against Torture,\(^\text{22}\) and US domestic criminal law against torture\(^\text{23}\) to permit aggressive interrogation techniques that previously have been understood to constitute torture or ill treatment. In an inquiry into allegations by US Federal Bureau of Investigation (FBI) agents regarding abuse of detainees at the Guantanamo Bay facility, Lt Gen Randall Schmidt determined that the following interrogation techniques were considered by the DoD to be humane and permitted by its interpretation of law: isolation for more than 5 months, sleep deprivation lasting 48 to 54 days during which interrogation took place 18 to 20 hours per day, degradation, sexual humiliation, military dogs to instill fear, and exposure to extremes of heat and cold and loud noise for long periods—and combinations of these techniques.\(^\text{24}\)

The American Medical Association has recognized that physicians’ ethical duties may exceed legal responsibilities and that when physicians believe a law is unjust, they should work to change it.\(^\text{17}\) In exceptional circumstances of unjust laws, a physician’s ethical responsibilities should supersede legal obligations.

As important, unlike the UN principles, the DoD guidelines make no reference to physicians or other health professionals avoiding harm to the physical or mental health of detainees. This is a departure from the traditional ethical obligation of “do no harm” and disregards the potential risk of harms from sleep deprivation, long-term isolation, severe humiliation, and imposition of fear and exploitation of phobias that have been reported by the detainees themselves,\(^\text{6}\) FBI agents who witnessed their condition,\(^\text{23}\) and the International Committee of the Red Cross.\(^\text{26}\) Witnesses have reported or observed anxiety, depression, suicidal ideation, disorientation, posttraumatic stress, and psychotic and paranoid behavior.\(^\text{6}\) These responses are consistent with the observations of clinicians who study and treat torture survivors.\(^\text{6,27,28}\) Although the question of whether obligations to patients may be properly subordinated to a military purpose has been much debated, there can be no dispute that in the context of interrogation practices that are harmful and violate international standards, physicians are never permitted to subordinate their ethical duties to the interest of the government, military, interrogators, or commanders.\(^\text{18}\)
### Table. Comparison of the United Nations’ Principles of Medical Ethics and Relevant Ethical Guidelines of the Department of Defense

<table>
<thead>
<tr>
<th>United Nations’ Principles</th>
<th>Department of Defense’s (DoD’s) Guidelines</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty to provide detainees with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained</td>
<td>Health care personnel charged with the medical care of detainees have a duty to protect detainees’ physical and mental health and provide appropriate treatment for disease</td>
<td>DoD provision does not apply to health care personnel engaged in activities not related to treatment</td>
</tr>
<tr>
<td>Contravention to incorporate any professional relationship with prisoners or detainees for a purpose that is not solely to evaluate, protect, or improve detainees’ physical and mental health</td>
<td>Duty in all matters affecting the physical and mental health of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees</td>
<td>DoD provision makes no specific reference to nonparticipation in torture or other cruel, inhuman, or degrading treatment</td>
</tr>
<tr>
<td>Contravention of medical ethics for health care personnel, particularly physicians:</td>
<td>Contravention of DoD to be involved in any professional patient-clinician treatment relationship with detainees for a purpose that is not solely to evaluate, protect, or improve detainees’ physical and mental health</td>
<td>DoD provision does not apply to nontreatment health care personnel</td>
</tr>
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<td>Contravention to participate in any procedure for applying physical restraints to the person of a detainee unless such a procedure is determined in accordance with medical criteria as being necessary for the protection of the detainee himself/herself or is determined to be necessary for the protection of his/her guardians or fellow detainees, and is determined to present no serious hazard to his/her physical or mental health</td>
<td>Contravention of DoD policy for health care personnel: To apply their knowledge and skills to assist in the interrogation of detainees in a manner that is not in accordance with applicable law</td>
<td>DoD provision links these ethical principles to “applicable law”</td>
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<tr>
<td>No corresponding provision</td>
<td>No corresponding provision</td>
<td>DoD guidelines make no reference to nonderogable principles</td>
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<tr>
<td>No corresponding provision</td>
<td>Health care personnel engaged in a professional patient-clinician treatment relationship with detainees shall not actively solicit information from detainees for purposes other than health care purposes</td>
<td>DoD provision only applies to health care personnel who are engaged in treatment: This means that health care personnel who are not engaged in treatment activities can solicit information from detainees for purposes other than health care</td>
</tr>
<tr>
<td>No corresponding provision</td>
<td>Medical information, with approval of medical unit commander, may be disclosed to prevent harm to any person, to maintain public health and order in detention facilities, and for “any lawful law enforcement, intelligence, or national security-related activity”</td>
<td>DoD provision permits breaches of confidentiality for non-health-related concerns, including “any lawful law enforcement, intelligence, or national security-related activity”</td>
</tr>
<tr>
<td>No corresponding provision</td>
<td>Duty to report possible violations of applicable ethical standards</td>
<td>DoD provision establishes an ethical duty for documentation of abusive practices</td>
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<tr>
<td>No corresponding provision</td>
<td>Secretaries of the military departments and combatant commanders shall ensure that health care personnel involved in the treatment of detainees or other detainee matters receive appropriate training on applicable policies and procedures relating the care and treatment of detainees</td>
<td>DoD provision calls for training of health care personnel on the new guidelines</td>
</tr>
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*Principles and guidelines apply to health care personnel, particularly physicians.*
Another dimension of the new DoD guidelines authorizes physicians and other health care personnel to release detainee medical records for intelligence purposes. Although not specifically addressed by the Declaration of Tokyo or the UN principles, medical records of detainees are presumed to extend to prisoners, with various grounds for overcoming the presumption, and ethical guidelines require physicians to respect the confidentiality of prisoners' health records. The DoD guidelines permit an exception to the protection of confidentiality for intelligence, law enforcement, or national security purposes, although the records disclosed and purpose for which they are to be used must be recorded and approved by the medical unit commander.

According to Burton J. Lee III, former physician to President George H. W. Bush, the Pentagon's recent attempts to subordinate fundamental medical ethical duties to . . . distort traditional ethical rules beyond recognition to serve the interests of interrogators, not doctors and detainees. The DoD should put into place mechanisms that protect physicians when demands are made of them to facilitate or monitor torture or ill treatment of detainees.

**Official Authorization of Coercive Interrogation Practices**

Why would the DoD depart from an approach to medical ethics and interrogation that has been the norm for 30 years? Why would it establish guidelines that create the potential for abuse through participation of physicians in coercive interrogation that can amount to torture or cruel, inhuman, or degrading treatment? The approach US forces have taken to interrogation suggests that the new guidelines simply rationalize and justify interrogation practices in place and rely on physicians to advance them.

One of the most significant shifts in US policy in the aftermath of the attacks of September 11, 2001, was in the handling of detainees captured by US forces. In early 2002, deeming the fight against terrorism as a new kind of war, then White House Counsel Alberto Gonzales determined that the Geneva Conventions did not apply to Taliban and Al Qaeda detainees captured in Afghanistan. In this new war, more intrusive interrogation methods were deemed necessary, and in his words, rendering "obsolete Geneva's strict limitations on questioning of enemy prisoners." That decision, in turn, led US government lawyers to reinterpret previous legal restrictions on interrogation contained in US criminal laws against torture and led military leaders to depart from interrogation instructions that forbade any form of physical or psychological coercion during interrogations. In December 2002, the US secretary of defense approved interrogation methods at the Guantanamo Bay facility that could include threats of harm to the detainee, isolation for up to 30 days, hooding, deprivation of light and auditory stimuli, forced nakedness, sleep deprivation, exploitation of detainees' phobias, use of dogs to instill fear, and other forms of psychological coercion. The authorization of such acts as legal methods of interrogation represented a contradiction in US policy because they have been consistently recognized as torture and ill treatment by the US Department of State in its annual Country Reports on Human Rights Practices. In January 2003, after internal dissent, the authorization was withdrawn and a working group was appointed to reevaluate the interrogation policy at the Guantanamo Bay facility. In April 2003, the working group recommended many of the same coercive techniques approved in 2002. The secretary of defense did not categorically approve all of them, but allowed latitude for case-by-case determinations. By this time, detainees were entering US custody in Iraq, and later in 2003, then commander of US forces in Iraq Lt Gen Ricardo Sanchez approved a number of interrogation techniques that included dietary or environmental manipulation, sleep adjustment, isolation, use of military dogs to instill fear, yelling, loud music and light control, deception, and stress positions. The DoD has not disclosed which of these interrogation techniques continue to be used.

**Role of Physicians and Other Health Care Personnel in Coercive Interrogation Practices**

The developers of the new DoD interrogation policies also considered 2 roles for physicians and other health care personnel. First, the involvement of physicians and psychologists in coercive interrogation was deemed a form of detainee protection. For example, both the working group appointed to assess interrogation policies and Defense Secretary Donald Rumsfeld made repeated references to medical assessment prior to use of particular forms of coercion to ensure that the particular detainee was "suitable." Similarly, in Iraq, Gen Sanchez's approval of coercive techniques was linked to medical and psychological review. He directed medical oversight of dietary manipulation, sleep deprivation, and sensory deprivation and monitoring by medical or, in some cases, psychiatrists. In certain cases, psychiatrists had to formally approve particular interrogation plans. In Afghanistan, more than 30% of nonhospital-based clinical health personnel who were interviewed for the US Army surgeon general's report (the proportion of physicians was not specified) were either present during interrogations or were aware of other health care personnel who had been present during interrogations; in Iraq, the comparable proportion was 18%.

This involvement became formalized in Iraq and Guantanamo Bay when the DoD established behavioral science consultation teams (BSCTs) composed of physicians, psychologists, and others not involved in providing clinical care, whose functions include "consulting on interrogation plan and approach, providing feedback on interrogation technique, assessing fitness for interrogation, and reviewing interrogation plans." Until June 2004, BSCT members at Guantanamo Bay were permitted direct access to detainee medical
records. According to the review by the US Army surgeon general of medical care for detainees, the purpose of these teams was to “ensure the interrogation process is conducted in a safe, ethical and legal manner.”

Because the interrogators were using coercive techniques, physicians and other health care personnel, in some circumstances, could not avoid becoming involved in decisions concerning the intensity and duration of the pain and harm to be inflicted, or whether it was to be inflicted at all. Moreover, the involvement or presence of physicians and other health care personnel in the guise of protecting detainees can have the effect of legitimizing the infliction of harm in the eyes of interrogators and security staff. It is precisely this type of involvement that the Declaration of Tokyo and UN principles were designed to prevent. It is noteworthy that almost half of the BSCT staff interviewed for the Army surgeon general’s report indicated that they felt conflicted about the role and did not think their training was adequate for the prescribed role.

Second, the new DoD interrogation policies established a role for physicians and other health care personnel in designing and consulting on interrogation methods thought most likely to yield information from a particular detainee. The Army surgeon general’s report indicated that interrogators were instructed “to interact with medical personnel, in particular the BSCT staff.” Those BSCT personnel were engaged in “checking the medical history of the detainees, with a focus on depression, delusional behaviors, manifestation of stress, and what are their buttons.” This suggests that even if medical records were not shared with interrogators, the findings and diagnoses contained in them were. According to the Army surgeon general’s report, interrogators were also trained to use BSCT staff to assist them with “obtaining more accurate intelligence information, knowing how to gain greater rapport with detainees, and also knowing when to push or not push harder in pursuit of intelligence information.” Although the Army surgeon general’s report determined that BSCT staff were directly involved in consulting on interrogation plans and providing feedback on techniques, the report concluded that there was no evidence that BSCT staff or other health care personnel participated in abusive interrogation practices. However, we question this conclusion. The Army surgeon general’s report did not ask BSCT personnel if they had participated in, monitored, or otherwise aided interrogation techniques such as sleep deprivation, severe humiliation, exploitation of phobias, use of extremes of heat and cold, sensory overload, and isolation. In addition, it has been reported that the BSCT personnel in some cases provided information about detainee phobias taken from medical files.

An obligation to report abuse of detainees, as provided by a 2003 WMA resolution, could in theory be a means of limiting participation by physicians and other health care professionals in coercive interrogation. The new DoD guidelines, consistent with policy applicable to all US military personnel, impose such an obligation to report abuse and in this respect they go beyond the requirements of the UN principles. The Army surgeon general’s report found that medical personnel reported abuse they observed, but it is also clear that interrogation practices that are authorized by the command structure are understood by the DoD not to constitute abuse.

It is clear from the Army surgeon general’s report that the engagement of physicians in interrogation remains part of the DoD’s policy. The impact of the new DoD ethical guidelines is to justify and rationalize these roles, that is, to continue to allow physicians to support, facilitate, and monitor interrogations that Pentagon officials and lawyers have deemed acceptable but that are contrary to the spirit and letter of ethical guidelines physicians have previously followed.

Conclusion

US military officials’ efforts to promulgate ethical guidelines that enable physician participation in coercive interrogation practices are inconsistent with international principles of medical ethics and, if unanswered by the medical community, establish a dangerous precedent. We believe that the vast majority of military physicians support international principles of medical ethics and do not wish to practice under untenable circumstances. The physician’s duty to promote health and human dignity requires unity and action among both military and nonmilitary physicians to maintain the integrity of medical professional ethics and to earn the trust of those served.

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