Places That Medical Ethics Can't Find:
Preliminary observations on why health professionals fail to stop torture in overseas counterterrorism operations

Stephanie Erin Brewer, JD
Jean Maria Arrigo, PhD

Abstract

As the Bush administration's war on terror continues, the health community struggles to understand how medical professionals have stood by during episodes of severe detainee abuse in U.S.-controlled detention centers such as Abu Ghraib. However, less discussion has focused on the role of health professionals in what may be a far more torture-prone environment: the network of U.S. field counterterrorism operations, sometimes carried out in partnership with foreign allies who routinely use torture in interrogations. Drawing on a first-hand account of health professionals' participation in these settings, as well as established tenets of social psychology, we analyze several specific features of the environment of overseas counterterrorism operations that increase the probability of health professionals' complicity in detainee abuse. We conclude that structural and psychological pressures facing medical professionals in these operations are likely to lead (in most if not all cases) to their tolerance of some level of detainee abuse and violations of medical ethics norms.

I. Introduction: Interrogation ethics in field operations versus U.S.-controlled detention centers

Since September 11th, 2001, Americans have grappled with the reality that agents of our government use torture when interrogating captives in the "war on terror." Reacting against this practice, lawyers, politicians, and human rights advocates have strongly criticized the attempts of the Bush Administration to narrow the legal definition of torture so as to evade international and domestic law. At the same time, several widely publicized detainee abuse scandals have brought home the fact that cruel, inhuman, and degrading practices occur in U.S. detention centers. The Abu Ghraib detention facility is seared into public memory, thanks to photographs of the torture and humiliation of detainees by U.S. personnel. Meanwhile, the human rights community has continuously denounced inhuman conditions and treatment in Guantánamo Bay.

Given these high-profile cases, it is unsurprising that the health community has focused on the roles of health professionals in these detention centers. Bioethicist Steven H. Miles, MD, introduced his seminal account of medical complicity in the war on terror with the question, "Where were the doctors and nurses at Abu Ghraib?" He reasoned, "Medical personnel are always present in military prisons. Even if they did not personally witness the beatings, suspensions, and kickings, they certainly saw the injuries, distress, and fear that resulted from them."[1] Health professionals have thus struggled to understand how their colleagues could

[1] Steven H. Miles, OATH BETRAYED: TORTURE, MEDICAL COMPLICITY, AND THE WAR ON TERROR ix (2006).

stand by during episodes of severe detainee abuse, and to answer the question of whether physicians, psychiatrists, or psychologists can actually serve as effective checks on mistreatment of detainees.

Although protests against conditions in U.S. detention centers occupy the spotlight, an entire network of U.S. counterterrorism operations – arguably more sinister and responsible for more frequent and severe cases of torture – remains largely in darkness. This network comprises the field operations and the joint interrogation programs carried out overseas by U.S. personnel, often in conjunction with operatives of foreign countries. Available data suggest that these operations lend themselves to some of the worst cases of detainee abuse, as U.S. personnel operate outside of all public scrutiny and foreign interrogation teams may exercise control over detainees. Indeed, the environment of total secrecy in which these operations play out evokes the concern expressed by some commentators that "Guantánamo Bay has or will become a staged detention center, while more egregious treatment of detainees is conducted elsewhere."[2]

Advocacy and pressure against official U.S. torture policy and publicly known detention centers is imperative to help reverse the top-down authorization of torture in U.S.-controlled facilities. At the same time, public and scholarly analysis must finally address the broader range of secret "counterterrorism" operations being carried out in numerous locations around the world. Otherwise, the Bush Administration will have succeeded in framing the torture discussion by selecting which interrogation settings and techniques are open to limited scrutiny and which remain in total secrecy. Further, the health professions and human rights community will lack analysis of what factors specific to overseas operations may facilitate the use of torture and – crucially – whether health professionals can serve as an effective check on abuses during interrogations in these locations.

We offer a preliminary response to this gap, taking as our point of entry the role of health professionals in overseas field operations conducted by U.S. personnel in conjunction with foreign operatives. To address the issues raised by this particular type of operation, we first review some findings from social psychology that bear on the question of the moral agency of health professionals in such interrogation settings.

II. The influence of situational factors on participation in detainee abuse

Initially, one might question why the particular setting of an interrogation or detention should influence whether medical personnel in that setting collude in torture and other abusive practices against detainees. Health professionals, after all, are trained to place their patients' welfare first, regardless of the setting, and to heal wounds rather than stand by while they are inflicted. However, they are susceptible to the same situational factors that influence the thinking and behavior of all human beings. Specifically, decades of social psychological research demonstrate that human behavior is profoundly influenced by the immediate environment in which people find themselves, the normative messages they receive from their peers, and the real or perceived structural limitations to which they are subjected.

[2] Jonathan H. Marks, *Doctors as Pawns? Law and Medical Ethics at Guantánamo Bay*, 37(3) SETON HALL L. REV. 711, 713 (2007).

The power of one's surroundings to erode ethical boundaries is particularly great when a perceived authority figure or "expert" in the environment orders the use of physical or mental abuse.

In a series of studies beginning in the 1960s, psychologist Stanley Milgram demonstrated the overwhelming tendency toward obedience of authority figures by recruiting a variety of people for a study in which they were asked by an "experimenter" in a lab coat to administer electrical shocks to another person. This second person, introduced as a fellow recruit, was in reality an accomplice in the study, located in an adjacent room. In an initial study of forty participants, 65% obeyed the experimenter's orders through a series of escalating shocks that caused the 'victim' to pound on the wall in protest and eventually fall ominously silent, ending at 450 volts, past the level labelled as "Danger: Severe Shock."[3] Subsequent iterations of the experiment showed that if the participant was given a seemingly indirect role in administering the shocks – with another person actually pulling the switch – obedience to the maximum shock level rose to 93%.[4] These levels of obedience occurred despite visual and verbal indications from many recruits that they were deeply distressed by shocking the victim.

Milgram further discovered that people who merely read about the experimental set-up were completely unable to predict the behavior of experimental subjects. Psychiatrists and behavioral scientists, in particular, predicted that only a "pathological fringe" of one or two percent of subjects would administer the 450-volt shock.[5] This finding discourages belief in the capacity of health professionals to gauge the conduct of themselves or others in military interrogation settings.

In another now-famous study, social psychologist Philip Zimbardo and colleagues at Stanford University demonstrated how the specific environment generated in detention centers can lead even perfectly 'normal' people to engage in or tolerate detainee abuse. In 1971, Zimbardo recruited a group of twenty-four college students, randomly divided them into 'prisoners' and 'guards,' and observed the students' behavior as they played out these roles in a simulated prison. The researchers had to terminate the planned two-week experiment after just six days when several of the "guards" became so deeply enmeshed in their roles that they exhibited sadistic and dehumanizing behavior, while "prisoners" suffered emotional breakdowns.[6] Although some of the remaining guards later revealed discomfort or sympathy for what had happened to the prisoners, none of them had prevented their peers' abusive acts or quit the experiment.[7] The Stanford prison study provokes the question of how health professionals, cast also in the roles of military officers, could remain focused on their identity as healers in the face of pressures to prioritize their role as soldiers.

---

[3] Stanley Milgram, *Behavioural Study of Obedience*, 67(4) J. ABNORMAL & SOC. PSYCHOL. 371, 376 (1963).
[4] Stanley Milgram, OBEDIENCE TO AUTHORITY: AN EXPERIMENTAL VIEW 119 (1974).
[5] *Id.* at 31.
[6] Craig Haney, Curtis Banks, & Philip Zimbardo, *Interpersonal Dynamics in a Simulated Prison*, 1 INT'L J. CRIMINOLOGY & PENOLOGY 69 (1973).
[7] For a day-by-day description of the prison experiment, including a brief comparison of some of the results with the abuses committed by U.S. soldiers against Iraqi prisoners in Abu Ghraib, see the experiment's website, http://www.prisonexp.org/.

We stop with these few demonstrations of how strong situations can overwhelm participants' prior ethical commitments. We emphasize, however, that a full functional analysis of activity settings[8] and the performance of institutional roles[9] would further erode belief in the potential moral autonomy of health professionals who participate in military operations. Moreover, the stresses of war can diminish individual cognitive resources to a level that is morally disastrous.[10]

In light of this, we argue that health professionals cannot be expected to serve as effective checks on abuse of detainees in overseas counterintelligence settings. Further, not even victory in the legal battle over the definition of torture nor the adoption of adequate human rights policies in U.S.-controlled detention centers will solve the pernicious problem of health professionals' complicity in torture when the U.S. conducts operations in conjunction with rights-abusing allies. The health professions can take certain steps to reduce the chances of members taking part in abuse, such as developing specific ethical codes, training programs, and monitoring initiatives. Ultimately, however, effective prevention of complicity in torture may simply require the withdrawal of health professionals from the interrogation setting while certain alliances persist in the war on terror.

In the pages that follow, we identify and systematize some of the dynamics of overseas counterterrorism operations that have contributed to the complicity of health professionals in detainee abuse in the past. The data on which we base our evaluation consist of first-hand accounts of the participation of health personnel in overseas military intelligence operations, which come from the correspondence of a retired U.S. military intelligence liaison officer to local counterterrorist teams in Middle Eastern countries and elsewhere.[11] The officer served in the field from the mid 1970s to the late 1980s and has maintained his contacts in subsequent travels and roles.

III. Overseas field operations and interrogations: a tortured environment for health professionals

In many field operations, U.S. personnel do not fully control what happens to all detainees. Local counterterrorist police or soldiers may well be the first to capture and take custody of terrorist suspects. U.S. personnel then, if they wish to interrogate the suspects, may find themselves cooperating with foreign agents who routinely utilize torture to interrogate

---

[8] *See* Roger G. Barker, ECOLOGICAL PSYCHOLOGY: CONCEPTS AND METHODS FOR STUDYING THE ENVIRONMENT OF HUMAN BEHAVIOR (1968).
[9] *See* Erving Goffman, INTERACTION RITUAL ESSAYS IN FACE-TO-FACE BEHAVIOR (1967).
[10] *See* Jonathan Shay, ACHILLES IN VIETNAM: COMBAT TRAUMA AND THE UNDOING OF CHARACTER (1995).
[11] Anonymous, *Correspondence between a U.S. Counterintelligence Liaison Officer and Jean Maria Arrigo* (2007), INTELLIGENCE ETHICS COLLECTION, Hoover Institution Archives, Stanford University, Stanford, CA. (Restricted.) The early correspondence and supporting military documents were reviewed for authenticity on April 28 and 29, 2003, by political scientist C. B. Scott Jones, PhD, a retired U.S. Navy fighter pilot, intelligence collector and analyst, and congressional assistant.

individuals under their custody,[12] thus establishing a high baseline environment of tolerance for such treatment. The liaison officer who provided the first-hand accounts on which we base this chapter narrates the criteria for entrance to such domains:

> I took one or two people downtown with me and they did not pass the local cops' "test".... If the agent showed any unease with seeing a bloody or "damaged" prisoner who was ready to talk, they found themselves sitting in the lobby of the various interrogation stations sipping tea but not being allowed to meet with the political crimes interrogators anymore.[13]

Further, although concern over health professionals' involvement in abusive interrogations naturally focuses on points of contact between health professionals and detainees or between health professionals and military or intelligence personnel, an understanding of U.S. counterterrorism policy in this setting (and others) requires an examination of a much larger political picture. One element critical to the present discussion is the nature of U.S. alliances with the intelligence agencies of other nations engaged in counterterrorist operations. For instance, the U.S. competes with Russia and China for influence with intelligence agencies in Central Asian states (e.g., Uzbekistan) and therefore U.S. personnel are in a particularly poor position to try to reform their interrogation practices.[14]

Even in settings in which U.S. personnel do have direct control over detainees, moreover, commanders may pressure health professionals to participate in harsh treatment of these individuals. Merely to remain on the job, health professionals may be required to tolerate some level of cruel and degrading treatment. Thus even if a doctor's stated objective is to improve treatment of detainees, he or she may find that the price that must be paid for this opportunity is to become complicit in a certain level of abuse. The perceived high pressure to gather timely field intelligence and the possibly dangerous or violent aspects of the local

---

[12] We do not suggest that all foreign interrogators are likely to use torture. However, several of the specific allies with whom U.S. military personnel collaborate in overseas counterterrorism operations are precisely countries that have records of using torture.

[13] Anonymous, *supra* note 11, #8. The liaison officer himself espouses the social skills method of interrogation. He relates:

> If I could get a few answers to non-related questions, that was the opening we needed. If I could get someone to accept any small gesture of kindness... like a glass of tea, a special food item, a book, writing materials, etc., then we had them.... At my best, the subjects did not even suspect they were being interrogated, as I kept it low-toned and friendly. I often agreed with their beliefs and opinions to stimulate conversation.... I would have all I needed with these people, as they did not shut up.

Id. at #22. For a discussion of the social psychology of the relationship between interrogators and subjects of interrogation, see Clark McCauley, *Toward a social psychology of professional military interrogations, in* Jean Maria Arrigo & Richard V. Wagner, "TORTURE IS FOR AMATEURS": A MEETING OF PSYCHOLOGISTS AND MILITARY INTERROGATORS, 13(4) PEACE AND CONFLICT: JOURNAL OF PEACE PSYCHOLOGY 399 (Special Issue 2007).

[14] Stéphane Lefebvre & Roger N. McDermott, *Russia and the Intelligence Services of Central Asia*, 21(2) INT'L J. INTELLIGENCE & COUNTERINTELLIGENCE 251 (2008).

environment may contribute to a sense that the rules learned in medical or even military training are irrelevant or impossible to apply in the "real world."

Further, there is little to counterbalance these messages that abuse is unavoidable or normal. Overseas health professionals are distant and isolated from the larger medical community and immersed instead in the military command chain, where the duty to obey one's superiors and strong social conformity among peers can create a crucible of social pressure discouraging disobedience, let alone any type of whistleblowing behavior. Given the secrecy of the operations and detention sites in question, there is little to no possibility of external scrutiny by human rights groups or even by other government authorities, leaving health professionals with no source of external legitimation that would support dissent against abuses in the field.

a. Exclusion and dismissal of health professionals based on their objection to torture

Before doctors, psychologists, and others even arrive in the field, of course, U.S. intelligence personnel may exercise considerable control over who is allowed to participate and may explicitly exclude individuals with a demonstrated commitment to human rights. The liaison officer explains:

> I also would want to review the personnel files of any medical person we used [so as] to find a cooperative medical aid. If he were a member of a church organization, a member of Amnesty International… then I would not use this person…. You do not need touchy feely people in interrogations.[15]

If a doctor who arrives in the field nonetheless objects to detainee abuse, she or he will presumably face pressure and even shaming from colleagues who have internalized the view that anyone who refuses to collaborate in harsh interrogation techniques is too "touchy feely" to function in the field. In other words, commitment to human rights is seen as a sign of foolishness (as opposed to, for instance, the so-called "hard realist" position that the only rights you have are the rights you can defend.) If this enormous social pressure does not convince the individual to soften his or her support of human rights, he or she may be sent home, ensuring that the supply of medical personnel remains loyal to the intelligence mission rather than to human rights or other ethical standards. The liaison officer gives as a probable example of such expulsion:

> I saw an Army doctor on TV last night saying that US military personnel fired into a crowd and that it could have been better handled. That guy could be out of the country that day with no security clearance or chance of promotion.[16]

b. U.S. cooperation with torturing allies: a dangerous starting point

Arriving in an environment where abuse of detainees is the norm – especially when one feels that there is nothing one can do to stop it – greatly facilitates complicity in this practice. Health professionals may feel that if they do not or cannot exercise full physical control over detainees, they are not responsible for the treatment that these detainees receive at the hands of foreign interrogators or jailors. This dynamic is illustrated in the liaison officer's

[15] Anonymous, *supra* note 11, #499.
[16] *Id.*

observations on joint interrogation operations and U.S. involvement in the most severe acts of torture (or "Level 1" interrogation techniques):

> I do not know of a single instance, outside of Vietnam, where a U.S. intelligence member actually went Level 1 on a subject all by themselves. I guess I came about as close as anyone in even gaining access to the facilities where the interrogation took place. The idea of torture is viewed as uncomfortable by Americans. *I would not say it was done on our behalf, but as it was being done in the course of their investigation, I saw nothing to be lost by submitting questions and then talking to the subject before and after the sessions.*[17]

Moreover, this viewpoint opens a path to ever-closer involvement in torture. For instance, a health professional who arrives and is told by colleagues that "nothing can be done" about local allies' use of torture may then feel that there is little sense in objecting to abuse later inflicted by U.S. personnel during an interrogation, which may seem equally inevitable. More generally, from the perspective of ecological psychology, a person who enters a setting with an ongoing "program of activity" is virtually certain to take on one of the established roles in the program rather than challenging or disrupting the program.

c. Manipulation of health professionals to diminish loyalty to their patients

Aside from contending with structural pressures such as those identified above, health professionals may face direct manipulation by interrogators seeking to turn their task from caring for "patients" to helping defeat these same individuals in the war on terror. One tactic is to reinforce that the detainees are suspected of ties to violent terrorist acts. The liaison officer narrates:

> [S]ome of our medical personnel are aiding us more after I take them to see terrorist crime scenes. The psych guys are coming around as they cannot imagine a local [person] planning and directing an act designed to kill women and children of their own culture.[18]

Needless to say, first-hand exposure to the sites of terrorist attacks would affect many professionals' ability to treat detainees in a neutral manner. Even if there is no evidence of links between a specific crime scene and a specific detainee, the general impression given may be that the group to which the detainees belong (culturally, politically, or otherwise) consists of violent individuals with no regard for human life.

Added to this type of manipulation are specific forms of pressure that can be brought to bear against some military doctors. The liaison officer notes:

> Most of the PAs [physicians assistants] or doctors that we use have been through medical school due to military scholarships. They owe the military

[17] *Id.* at #13. Emphasis added.
[18] *Id.* at #641.

> big bucks. If they refused to aid us, then they might be brought up on charges of an internal trial and would be forced to repay the military.[19]

The vast majority of health professionals in contact with detainees are junior officers who owe the military for their graduate education. The mere threat of being forced to repay this debt immediately, even if not followed through, could be enough to compromise the impartiality of health professionals who are unsure whether to collaborate in or speak out against abusive interrogation techniques.

As demonstrated in the passages above, health professionals may be perceived less as free agents than as targets of manipulation. Indeed, intelligence agents consider doctors and scientists among the easiest professionals to manipulate, due to a perception that such professionals' principles render them predictable; that they become passionately attached to their projects; and that they tend to be ambitious in their national security careers.[20]

In a more direct approach, some commanders may simply order medical personnel to place their loyalty to their country above their medical care for a detainee, including by trading medical treatment for information during interrogations. The liaison officer reports, "Our doctors have their orders as well to get the intel[ligence] out of the terrorists,"[21] and elaborates:

> [Detainees] inflicted with dysentery and confined to a small airless cell awaiting interrogation might well wish for a few pills. Those with wounds will usually offer to talk if they get to be seen by a medic.[22]

As refusing medical treatment until a detainee gives information violates medical ethics, one might imagine that health professionals facing such orders would decline. However, aside from the inherent pressure to obey orders given by one's superiors, this practice may actually seem to be a humane way to help the detainee, particularly when compared to the available reference points of torture among other interrogators or teams of foreign allies. As one example, the liaison officer relates:

> ...I have seen other nations use doctors who are also trained interrogators. The stuff they give you for stress tests to check out your heart works well to convince the suspect he is dying.[23]

A U.S. doctor who is asked to trade treatment for information may thus feel reduced ethical pressure to refuse this arrangement, since this technique seems comparatively mild when viewed against the behavior of foreign medical personnel or other interrogators. It may simply appear to be a way to rescue the detainee from his or her suffering.

---

[19] *Id.* at #496.
[20] *E.g.,* Oral history interview by Jean Maria Arrigo with Ernest Garcia, OSS-CIA covert actions operator, Albuquerque, NM (Oct. 21 & 22, 1995), *in* ETHICS OF INTELLIGENCE AND WEAPONS DEVELOPMENT ORAL HISTORY COLLECTION, Bancroft Library, University of California, Berkeley, CA.
[21] Anonymous, *supra* note 11, #696.
[22] *Id.* at #701.
[23] *Id.* at #491.

d. Isolation from the world of government oversight and human rights norms

Overall, the combination of isolation in a foreign environment, pressure to detect perceived threats to national security, and the explicit messages of fellow intelligence personnel may generate the perception that far-off international laws or ethical codes are simply not the relevant moral framework on the ground. Rather, the relevant rules may be seen as the practices that have developed to "get the job done." This perception is reinforced when local commanders tell their subordinates to act in ways that contradict the official rules, especially when contact with the outside world or the official rules is infrequent and superficial:

> I recall that every other year an inspector would stop by and ask what we all would do if ordered to eliminate a foreign national. We would all say, "report them as per regulations," then the inspector would leave. Then what we were told to do was often in conflict with this idea.[24]

Beyond eroding the perceived applicability of official rules, this type of contrast may create an environment in which those individuals who do try to apply the rules are seen as foolish or irrelevant by their peers. Health professionals who are uncomfortable with seeing abuse but who may be unsure which set of norms should apply will then feel additional pressure to keep silent, or they may reason that they would not be taken seriously even if they were to speak out.

Further, the infrequency of meaningful supervision from military inspectors referenced above pales when compared to the impossibility of human rights oversight in secret detention facilities or mobile intelligence operations overseas. Indeed, the human rights group Reprieve recently revealed that the US operates "floating prisons" by detaining and interrogating prisoners onboard numerous ships, where physical abuse is reportedly worse than in Guantánamo.[25] The ships are surely staffed with health professionals, whatever their roles. This use of ships as moving, clandestine detention centers exemplifies the US strategy of keeping the number and location of its detainees, as well as the types of abuses committed against them, inaccessible to observers who might use this information to denounce US human rights violations in the war on terror. The essential role that secrecy plays in undermining human rights is clear in the liaison officer's perceptions:

> It's so nice to be secret…. So secret that most of the military or government have no idea where [you] are. No rights, human or otherwise have to be dealt with. Let a few inaccessible places be released through controlled media informants and then [Amnesty International] and all the rest will be concentrating on those places while we continue to work in the real centers.[26]

The dichotomy presented is clear: there are detention centers that the government and perhaps human rights groups know about, and then there are the "real" centers. Likewise,

---

[24] *Id.* at #29.
[25] Duncan Campbell & Richard Norton-Taylor, *US accused of holding terror suspects on prison ships*, THE GUARDIAN, June 2, 2008, *available at* http://www.guardian.co.uk/world/2008/jun/02/usa.humanrights.
[26] Anonymous, *supra* note 11, #314.

there are human rights norms (designed for consumption by the media) and then there is "how things work" to accomplish the mission. Health professionals are unlikely to be entirely immune from the constant pressure generated by this dichotomy.

e. Role of health professionals in facilitating torture by other interrogators

Thus far we have discussed the influence of foreign and U.S. interrogators on health professionals' behavior; however, health professionals themselves may also influence the behavior of those around them in ways that can facilitate detainee abuse. For instance, the presence of medical professionals may lend an air of legitimacy or safety to an interrogation, as interrogators feel that they have the implicit approval and oversight of an expert who will not let anything truly harmful occur. The presence of a doctor may also alleviate fears of moral or even legal liability, to the extent that such worries are present: the interrogator may feel that any medical problems that arise will be the responsibility of the doctor, who, as the expert in health, should have monitored and prevented truly harmful complications. Thus emboldened, interrogators may use harsher techniques than they would in the absence of the health professional.

A particularly disturbing use of doctors emerges from the commentary of the liaison officer, who notes the possible utility of medical personnel in this scenario:

> Say if in my case where we had intel[ligence] about an assassination I guess we could go grab a terrorist (hopefully he would be in the same cell or group as the ones who were to attack) and give him various drugs to soften up his hostility and do the Dustin Hoffman dentist trick of working on the nerves of the teeth. But I would still have to guide his interrogation of the subject of the assassination and stay in it until he would say anything to make us stop. If he were to go to donkey heaven [i.e., die under torture] right off the bat before interrogation I would like to have had a quick and fast medical check up to detect a heart problem, high blood pressure, and to know what drugs he might be on at the time.[27]

This account is disturbing on several levels, as it demonstrates a methodology of "grabbing" and torturing someone who may – or may not – be related to a group of people about whom there is information about a possible attack. The role of the doctor in this scenario is perverse: by giving the patient an exam and a clean bill of health, she or he is effectively opening the door for the detainee to be subjected to severe torture. Without the doctor's intervention, the interrogators might continue to have at least some level of uncertainty about the detainee's ability to withstand brutal techniques and might therefore refrain from certain acts. With the approval of the doctor, however, these inhibitions will likely be reduced.

Another scenario in which doctors may facilitate torture, particularly psychologists, is when interrogators ask for these professionals' help in evaluating whether a detainee appears to be lying, concealing information, or reacting with signs of stress to certain words or questions. If a psychologist expresses the opinion that a detainee does appear to be concealing information, interrogators may feel freer to apply the harshest interrogation techniques,

[27] *Id.* at #499.

inasmuch as the detainee supposedly has the ability to stop the abuse by giving information. In effect, the perceived blame for the abuse shifts onto the detainee.

f. Use of health professionals to keep interrogators obedient to the military

Health professionals and interrogators alike may find themselves manipulated by superiors seeking to stifle dissent among subordinates. The liaison officer explains that a common response to a subordinate's dissent is for the superior to send the subordinate for a mental health evaluation. This tactic seeks to intimidate the soldier, demonstrating that even though he or she may be perfectly sane, the military has the power to have the person declared incompetent, potentially ending his or her career:

> The military has always used the nut ward as a hanging sword over each agent. The doctors often cannot figure out why you are there and ask their visitors to take the tests, then send them off top duty again.[28]

This technique has particular application to subordinates who may speak out against military policies or practices, a situation that would apply to those who wish to denounce abuses against detainees, including military doctors. As one example of criticism leading to the hospitalization of a soldier, the liaison officer relates:

> You go and speak out like the NCO did today in Iraq when he asked Rumsfeld about the armor for the Humvees. He was called to the base commander's office, reduced in rank, and is under observation in the psych ward. It only took an hour or two after he jumped up and spoke out....[29]

g. Use of health professionals to mislead the public and divert criticism

Finally, the mere presence of health professionals in closed detention sites may be cited by the military to cover over abusive treatment of detainees:

> 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....[30]

As seen in this excerpt, health professionals can face a lose-lose situation when cooperating in interrogations in closed sites. On one hand, those who object strongly to detainee abuse may be screened out before arrival or dismissed once their objections surface. On the other, those who remain on assignment, even if their goal is to improve detainee treatment, become part of a blanket public justification for the military's interrogation techniques, thus helping to ensure the continued secrecy and use of the very types of coercive interrogation to which they may object.

---

[28] *Id.* at #464.
[29] *Id.*
[30] *Id.* at #538.

h. Blurring of boundaries between intelligence and health professionals

Throughout our analysis, we have distinguished between military/intelligence and health professionals, as if they were distinct persons occupying distinct roles, beholden to different codes of ethics. The reality is not so simple. Many health professionals were soldiers first and later received their scientific and clinical training. Even those who trained first in the health professions may feel that their first loyalty or sense of identity belongs to the national security community, not to their health professions. The liaison officer has remarked appreciatively on some such doctors:

> At least we don't have to put on the white coats and play doctors anymore. We have enough CI [counterintelligence]-employed real doctors to help us now....[31]

Civilian health professionals would do well to remember that their colleagues in the armed services have taken loyalty oaths that may directly compete with the ethics codes of their professional associations. Deep into field operations abroad, official standards of conduct for health professionals will not necessarily trump the perceived needs of the military field mission – even when, as here, the result may be that members of the health professions act against the interests of their patients and in violation of national and international law.

IV. Conclusion: First, do no harm

Much of the public and scholarly debate on interrogation techniques under the Bush administration has focused on the legal definition of torture. Yet a closer understanding of the unique, self-contained environment of field operations abroad demonstrates just how distant and unenforceable legal definitions of torture often are in this environment. U.S. counterterrorism operations in allied countries with traditions of torture *will* bring U.S. interrogation personnel into direct or indirect contact with torture interrogation. In such liaisons, U.S. health professionals' adherence to ethical standards cannot be guaranteed by laws or regulations alone.

The perceived distance, inadequacy, or irrelevance of pre-existing ethical codes applies as well to members of health professions, who face manipulation, explicit and implicit orders, threats to their careers, conflicting identities, and structural pressures to conform to non-patient-centric ethical norms in interrogation settings. Thus if health professionals are to continue serving alongside field operations abroad and attending interrogations of detainees in the war on terror, the health professions as a whole must find a way to penetrate these settings and to make human rights norms and medical ethics codes relevant and powerful on the ground.

This task, although difficult, could theoretically be undertaken by health professionals' associations in collaboration with military ethicists. For instance, such associations could develop specific ethical guidelines and training for health professionals (such as through role-playing) in how to respond to various interrogation situations. This would help to ensure that the health professional is not left to resolve novel ethical conflicts at the very moment that he

[31] *Id.* at #342.

or she is being pressured to follow an unethical order. Such guidelines and training programs could take as their starting point some of the dynamics discussed above.

Another seemingly necessary initiative would be to set up a more regular contact mechanism between field medical personnel and medical ethics boards. Mandatory, frequent contact with the outside world would help professionals in the field to feel that ethical guidelines were present in their work and that they were accountable to their profession in upholding these guidelines, empowering them with external support and legitimacy for refusing to be complicit in torture. Yet this course is impractical: among other complications, secrecy requirements for intelligence would demand prior clearance of the medical ethics boards, secrecy oaths, and ongoing monitoring of their conduct.

Additionally, such efforts at specialized training and professional solidarity, if successful, would likely become victims of their own success. That is, once health professionals in the field truly *did* stop facilitating or tolerating abuses, they would likely be dismissed and replaced with more willing collaborators. As noted by the liaison officer:

> The use of doctors or PAs [Physicians Assistants] might become too much later on so we would then make use of our ParaRescue [PR] or Combat Medics for medical expertise in interrogations. The PR's role is that of a Special Operations commando first and medic second....[32]

Even this scenario represents an improvement in at least one sense. Namely, although abuses against detainees would persist, the large-scale removal of medical personnel from contact with interrogations – to the extent that it came to light – would also remove the normative stamp of health professionals from torture and harsh interrogation techniques, depriving the government of an instrument that it can currently use to mislead the public about these subjects.

The excerpts above suggest that to end the abuse of detainees in secret detention sites and joint field operations abroad, it is necessary to change the inherent dynamics of such operations through, among other things, the issuance of clear orders from the highest levels of government that detainees' rights are to be respected; disassociation from foreign allies who practice torture; and a reduction in the structural pressures identified here that lend themselves to abuse and torture. In other words, a significant change is required in the stance and priorities of the U.S. administration in the so-called war on terror.

It is doubtful that on-site health professionals constitute the ideal (or even a viable) point of entry for making these changes. For reasons already mentioned, merely to stay on-site, many such professionals may feel forced to adapt their skills to the environment of abuse rather than transforming the environment itself. Although the removal from overseas interrogation settings of health professionals who refuse to become complicit in torture may seem like a disappointing outcome,[33] what we have sought to demonstrate in this chapter is that the alternative – that is, the presence of medical personnel who avoid being removed from such

---

[32] *Id.* at #503.

[33] We do not suggest that the withdrawal of medical personnel from all assignments where detentions might occur is either necessary or feasible; rather, we refer to the removal of such professionals from counterterrorism interrogations and their immediate settings.

assignments – by definition does not represent an effective systemic check on the abuse of detainees. Put simply, the historical record of health professionals' involvement in diverse cases of detainee abuse, illuminated by the robust empirical findings of social psychology, imply that few health professionals will uphold professional codes of ethics in abusive interrogation settings.

Acknowledgment

We deeply thank the military liaison officer who contributed his observations of interrogations in difficult settings and permitted our analysis, which may diverge from his own position.

Word count: 5935