*Problems of Detention*

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By 2007 a total of 97 detainees had been part of the RDG program. Prior to RDG assuming control, [redacted][119] About half the 97 RDG detainees came into Agency hands in 2003, and a fourth in 2004. In the final two years prior to the transfer of remaining detainees to Guantánamo Bay in September 2006, only 5-6 new detainees entered the program, with only two subjected to enhanced measures.

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When possible, RDG arranged to transfer detainees no longer of intelligence value to the U.S. military, or render them to another country. Despite new arrivals, this effort reduced the total number of detainees in Agency control from [redacted] at end of 2003, to just [redacted] in the spring of 2004, and just [redacted] at the beginning of 2005. This figure remained relatively constant for the next year, until an accelerated effort during 2006 reduced the number remaining for transfer to Guantánamo to 14.

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Viewed differently, about 2/3 of detainees coming into Agency hands prior to October 2004 had been transferred out by circa the end of 2004; their detentions had ranged from a month to almost two years, probably averaging not much more than a year. A large majority of the detainees *not* transferred out of Agency hands by the end of 2004 continued to be held for almost two more years. Their overall detention probably averaged about three years, and as true long-term detainees they presented a different set of medical challenges.

OMS thought of the detainee experience as divided into three phases: rendition and initial interrogation, sustained debriefing, and long-term detention. With the first two phases typically lasting only a few weeks to a few months, by far the greatest amount of a detainee's time was spent simply in detention.[120] With the sharp late-2004 decline in new arrivals, the medical role thus became almost exclusively attending to long-term detainees.

Agency detainees were, as a group, basically young and healthy. Given bi-monthly or quarterly medical check ups (more often if indicated), a healthful diet, vitamins, vaccines, adequate rest, and some opportunity to exercise, most eventually were in better shape than when they came into Agency custody. Some were even willing to comment that they looked fitter than they had in years.

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[120] RDG characterized things similarly: an interrogation/exploitation phase lasted 1-10 weeks, with the most intense period rarely exceeding two weeks; a second, transition phase usually lasting two to three months during which the detainees cooperation was validated; and a third, debriefing phase which lasted from two to several months and in rare cases—such as AZ—for as long as three years.

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A few detainees arrived with existing injuries, though none in as serious condition as AZ. Ahmed Guleed had sustained a GSW several months prior to capture, and arrived at with a colostomy and frozen left elbow. Two detainees arrived with malleolar fractures sustained jumping from a high wall. Another detainee arrived with a broken finger. All required follow-up care and none were subjected to stressful interrogation either initially or later. The fracture group soon was transferred elsewhere, but Guleed's colostomy was successfully maintained for over two years before circumstances allowed a revision to be arranged. In the interim, he received professional guidance on physical therapy to restore motion in his left elbow.

Medically, of the nearly 100 detainees evaluated, none was HIV-positive, only three were hepatitis B and two hepatitis C antigen positive. One arrived with a sexually-transmitted disease—a chancroid—inflicted, he said, by a genii (djinn). Most complaints while in detention were for relatively minor ailments, such as headaches, mild musculo-skeletal symptoms, rashes, gastrointestinal upsets, or an occasional pharyngitis. Eventually a few dental problems arose, treated by an RDG contract dentist who from early 2004 periodically flew to detention sites to provide both routine and focused care. Only a single dental emergency arose, in 2006, Basic vision checks were performed by OMS personnel, and prison-safe glasses obtained. AZ initially preferred to wear a patch over his left eye socket, but eventually requested an artificial eye; this was obtained, a near perfect match to his good eye.

Over time, non-emergency issues arose which required capabilities beyond that available at the detention sites. Guleed's colostomy needed to be reversed; Gul needed a biopsy for an enlarging thyroid; al-Hasawi had hemorrhoids and a rectal prolapse; three detainees required endoscopy for GERD symptoms; and liver biopsies were indicated for those with chronic hepatitis B or C.

OMS once hoped the Department of Defense could provide this specialized care. When several detainees were transferred to Guantánamo Bay in early 2004, a test case presented.
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As this concern was being addressed, the issue became moot. The pending Supreme Court decision that could have mandated access to all Guantánamo detainees led to the closure

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While pursuing the DOD option, RDG and OMS also evaluated over a dozen third-country alternatives. A combination of substandard medical care and/or concerns about media exposure and internal politics had ruled out all of those initially considered.

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Attending to the psychological well-being of detainees was at least as challenging as dealing with their physical needs. The impact of sustained isolation was the primary problem and proved more psychologically challenging than had the interrogations. By design, no contact with other detainees was allowed in Agency detention facilities and continuous white noise prevented them from hearing one another. Though physically comparable to modern U.S. prisons [redacted] (b)(1) the detainee cells nonetheless were small and windowless. (b)(3) NatSecAct

[121] On the basis of blood tests, three of the detainees, including the subject with rectal prolapse once were considered candidates for liver biopsy. Of these, one declined to be biopsied, one was transferred [redacted] before a biopsy could be arranged, and further testing of the third eliminated the need.



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Initially, of course, detainees had weeks and sometimes months of frequent, often intense contact with Agency interrogators and debriefers. But as this phase ended, detainees eventually were left without the intellectual stimulation such contact afforded. Initial attempts to fill this void included "homework" (even when no intelligence requirement existed), the provision of books and other reading material, and mandatory staff contacts. At the extreme, KSM was invited to present staff lectures on various subjects.

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OMS concerns about the effects of long-term detention led to an acceleration of RDG efforts to provide more stimulation to the detainees. (These concerns were shared by RDG personnel working directly with the detainees, and by D/NCS, former Chief of CTC). This included the provision of videos and games (eventually including hand-held computer games), and the implementation of "social" or "rapport-building" sessions, during which staffers might play cards or other games with a detainee or hold informal philosophical discussions. In this setting, many detainees came to view some of the staff, even prior interrogators, as their "friends."

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Throughout the years of the RDG program OMS psychologists and psychiatrists made at least quarterly trips to each facility, and conducted extensive interviews with every detainee. Notably, in view of the terrorist behavior, at intake no detainee had a diagnosable mental disorder, not excepting such Axis II disorders as anti-social

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personality.[123] (This was consistent with the findings on terrorists held in the Federal prison system.) Some eventually developed adjustment problems, and at least two requested and were provided with anti-depressants. Another asked for Prozac, which he had taken previously, and was sure it would make him feel better. It didn't, so the Prozac was discontinued. Particular effort was made to identify signs of post-traumatic stress disorder (PTSD). Notably, even among those subjected to the most intense coercive measures, there were no indications of the emergence of PTSD.

OMS practice regarding the treatment of detainees who were having difficulties with their situation was to work with RDG to ameliorate conditions as much as possible within security bounds. Although at times CTC managers were frustrated by OMS unwillingness to involuntarily medicate detainees who were "acting out," medications were offered only for bona fide medical indications and with the prior consent of the detainee. This mirrored the Federal Bureau of Prisons policy on involuntary medication.

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At least two detainees did appear to feign mental illnesses. One, (b)(1) (b)(3) NatSecAct was concerned that guards would learn of his links He suddenly stopped speaking and isolated himself from the others in his group cell However, he remained visibly attuned to everything going on around him, and was appropriately attentive to his activities of daily living. When he was discretely reassured that his "secret" was safe with us, he suddenly was able to express appreciation. On transfer to an entirely U.S. manned facility, his symptoms cleared.

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The second case was Firas al-Yemeni who once had passed a kidney stone. He began hoarding medications, self-inducing vomiting, defecating on the floor and crawling through his feces. At times he appeared to fake his symptoms, and his endoscopy had been normal. The best judgment was that most of his symptoms were either psychosomatic or factitious. Eventually he was transferred out of the RDG program, and his medical care assumed by the recipient country.

From the time of AZ's capture there was concern that a martydom-oriented detainee would deliberately injure himself, or attempt suicide. Accordingly, all detainees were intensively monitored during their initial interrogations and had video-monitoring of their cells throughout their detention. Aside from a rare refusal to eat or drink, however, most detainees were attentive to their person health and no seriously self-destructive behavior was evident. One detainee—Majid Khan —twice made scratches across his wrists (not requiring suturing) when he felt he was not getting enough attention

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[123] In 2006 author Ron Suskind reported, in a much repeated claim, that at the time of capture AZ was found to have a serious dissociative disorder, a diagnosis inferred from AZ's diaries, which were written using several personas. In reality, this was an entirely literary device, without psychiatric overtones. Ron Suskind, *The One Percent Doctrine: Deep Inside America's Pursuit of Its Enemies Since 9/11* (New York City: Simon & Shuster, 2006), pp. 95-100.

from the facility chief. Another detainee was found to woven a noose from clothe in his cell.

Fewer than five detainees ever refused food. OMS (and RDG) policy—which was based on that of the Bureau of Prisons—allowed a hunger strike to continue unless there was some apparent impact on the detainee's health, or his weight fell to less than 90% of average for height. If one of these thresholds was reached, the health risks were explained. If a detainee still continued to refuse food, he was fed through an NG tube. Tube feeding would have been accomplished involuntarily if necessary, but the few who required it were compliant and often assisted with the procedure. Typically, hunger strikes ended soon after these feedings began.

(b)(1) (b)(3) NatSecAct *One detainee, of some later notoriety, ended a hunger strike as soon as an NG* tube first was laid out and lubricated. Khaled al-Masri was a German citizen [redacted], transferred to the Agency and rendered [redacted]
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(b)(1) (b)(3) NatSecAct Subsequently al-Masri went public with an account embraced by the press and the ACLU, which variously alleged imprisonment [redacted] injection with drugs (including rectally), forced feeding, beatings, and sexual abuse, none of which was actually true. He had never even been interrogated, much less abused. An ACLU-supported al-Masri lawsuit against the Agency eventually was disallowed by the courts, and later he was arrested in Germany on a charge of arson—the result, his lawyer said, of a "nervous breakdown attributable to the torture he had endured in CIA custody".[124]

OMS (and Bureau of Prisons) policy on forced feedings was directly counter to that of the World Medical Association, the American Medical Association, and most medical human rights groups. These groups held that the right to patient self-determination prevailed over all other considerations. Within OMS, there was never any consideration given to allowing a detainee to starve himself to death, or otherwise kill himself. As within the Federal prison system, RDG detention facilities were carefully designed to be as suicide-proof as possible. Suicidal behavior, should it have occurred, would have been seen as a reflection of the psychiatric stresses associated with

[124] The first of scores of article on the al-Masri case was "German's Claim of Kidnapping Brings Investigation of U.S. Link," *New York Times*, 9 January 2005. His arson arrest and involuntary admission to a psychiatric ward was reported in, "German who claimed to be CIA torture victim detained on suspicion of arson," *International Herald Tribune*, 17 May 2007. A particularly trusting article, which also repeated the rectal suppository allegation, was Jane Mayer, "The Black Sites," *The New Yorker*, 13 August 2007. Mayer characterized al-Masri as "one of the more credible sources on the black-site program"

incarceration and an uncertain future. Moreover, it was clear that had a detainee managed to kill himself any commendation for the Agency commitment to self-determination would have been lost in the demands for an immediate investigation.

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[redacted] ABC News began a series of related reports—which also won their authors a Pulitzer. These reports enumerated and briefly described six "enhanced interrogation techniques" said to be used by the Agency. Four techniques were correctly described: the attention grab, attention slap, the belly slap, and "long time standing." "Standing" for more than 40 hours, and associated sleep deprivation, was said

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to be "effective." A fifth identified technique was "the cold cell" in which a prisoner was said to be kept standing at a temperature near 50 degrees while being doused with cold water. This claim was only partially correct: standing and dousing were done, but not in a cold room. The sixth identified technique was the previously reported "water boarding," though now described as binding the detainee to a board, wrapping cellophane around his face, and then pouring on water.

This waterboard treatment was said to result in "almost instant pleas to bring the treatment to a halt." Ibn Shaykh al Libbi was said to have been broken by it after two weeks of progressively harsher techniques had failed. CIA officers subjected to the waterboard during trainings were said to last an average of 14 seconds. AZ began cooperating after 31 seconds, while KSM had impressed interrogators by lasting between 2 and 2½ minutes.

All but one of the 12 high value targets held to date were said to have required waterboarding. The exception was Ramzi bin al Shibh, who reportedly broke down after walking past the cell in which KSM was held. [redacted]

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Despite the Pulitzer, and the frequency with which other media sources repeated ABC claims, at best they again reflected poor guesswork by sources with no direct knowledge of the program. There never was a "cold room" technique. Cellophane was never part of the waterboard.[134] Only three (not eleven) detainees had been on the waterboard. Shaykh al Libbi never was on the waterboard. Neither AZ nor KSM "broke" on the waterboard. While AZ once had water applied for 30 seconds, KSM never had an application exceeding 40 seconds. [redacted]

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[133] "CIA's Harsh Interrogation Techniques Described," ABCNews, 18 November 2005.

[134] Misreporting about the waterboard was common. For at least a year after first reporting of waterbaord use, the *New York Times* described it as involving literal submersion under water. The first to correctly characterize the technique was *Newsweek* . Eventually the *Chicago Tribune* carried the rather detailed description by a Navy SEAL who had experienced the technique himself, and who also reflected conventional SERE wisdom in saying it was "instantly effective on 100 percent of Navy SEALs." See "A Tortured Debate," *Newsweek*, 21 June 2004; "The Debate Over Torture," *Newsweek*, 21 November 2005; "Spilling Al Qaeda's Secrets," *Chicago Tribune*, 28 December 2005

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Khaled al-Masri—whose allegations of drugging, torture, and forced feeding were all fabricated—

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Beyond the fiscal costs, these closures and resulting moves took a visible toll on the detainees. For them, movement was very stressful because of the associated uncertainties. Attending medical personnel generally talked detainees through this process, emphasizing that the change was not a reflection on their behavior (i.e., it wasn't punitive), but rather was compelled by outside factors. Nonetheless, the associated anxiety often triggered some depression, occasionally requiring treatment. The Agency later was faulted for subjecting detainees to multiple moves, but this was not by design. Had circumstances allowed, most detainees would have gone from an initial interrogation/debriefing site, to a final-long term detention facility. Detainees of lesser value would have been turned over to the DoD or returned to their home country.

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*Ethics*

One group energized by media exposés and human rights reports were those concerned with the ethics of medical participation in detainee programs, including the role of psychologists. In the 18-month period from July 2004 to December 2005, the *New England Journal of Medicine* carried five different articles touching on the subject, ranging from "Doctors and Torture" to "Glimpses of Guantanamo—Medical Ethics and the War on Terror."[141] A particularly pointed article under the principal authorship of the president of Physicians for Human Rights also appeared in *JAMA* on "Coercive U.S. Interrogation Policies: A Challenge to Medical Ethics" (September 2005).[142]

The thrust of these articles—most of which were focused on the more visible and widely-reported practices of U.S. military personnel—was that there was little or no place for medical personnel or psychologists in interrogations, and especially those involving coercive techniques or designed with medical input on detainee vulnerabilities.[143] The interrogation techniques widely reported in the press violated the patient-centric ethic which should govern all medical practice. If not outright torture, the interrogation techniques were cruel, inhuman and degrading, and thus illegal under international and "humanitarian" law.

In general OMS personnel long since had resolved personal ethical concerns by the time such commentaries appeared in 2004 and 2005. The Office believed ethical considerations were entirely personal, so from the outset made participation in the RDG program voluntary. Withdrawal without penalty was allowed at any time. The 2002 DoJ guidance was the foundation of most decisions to become involved, but program experience reinforced the initial commitment. With the exception of the waterboard—last used in March 2003, and by late 2004 unlikely to be used again—the actual

[141] Robert J. Lifton, MD, "Doctors and Torture," *NEJM* 351(5):415-416 (29 July 2004); M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *NEJM* 352(1):3-6 (6 January 2005); George Annas, JD, MPH, "Unspeakably Cruel—Torture, Medical Ethics, and the Law," NEJM 352(20):2127-2131 (19 May 2005); M. Gregg Bloche, MD, JD and Jonathan H. Marks, "Doctors and Interrogators at Guantanamo Bay," *NEJM* 353(1):6-8 (7 July 2005); Susan Okie, MD, "Glimpses of Guantanamo—Medical Ethics and the War on Terror," *NEJM* 353(24):2529-2534 (15 December 2005).

[142] Leonard Rubenstein, JD, Christian Pross, MD, Frank Davidoff, MD, and Vincent Iacopino, MD, PhD, "Coercive U.S. Interrogation Policies: A Challenge to Medical Ethics," *JAMA* 294(12):1544-1549 (28 September 2005); also of note was Steven H. Miles, MD, ""Abu Ghraib: its legacy for military medicine," *The Lancet* 364:725-729 (25 August 2004). Miles later expanded his piece into a book-length treatment, in Stephen H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006)

[143] Much of this attention was triggered by a June 2004 *New York Times* account of the use of Behavioral Science Consultation Teams (BSCT, or "biscuits") to facilitate interrogations at Guantánamo. Biscuits were composed of a psychiatrist, psychologist, and medical assistant, who studied detainee records, including medical records, to develop effective interrogation strategies. Critics held that this violated patient confidentiality; some believed the medical personnel should not be involved, even without access to individual records. Though declining a recommendation to do away with these teams, the Pentagon did eliminate their access to the medical files.

application of enhanced techniques had been much more modest than the press image, and reassuringly free of enduring physical or psychological effects. Collectively, these techniques had been dramatically successful in producing indispensable intelligence not otherwise obtainable. Though often discounted in the press, the information that flowed out of detainee interrogations and debriefings had led to the capture of other key al-Qa'ida players and the disruption of several planned attacks. Lives unquestionably were saved.

The summer 2004 articles which launched the ethical discussion in the U.S. also clashed jarringly with an ongoing series of al-Qa'ida kidnapping and beheadings. In contrast to what seemed a sometimes utopian ethicist view, medical personnel saw themselves as living within a very real and dangerous world, fulfilling a societal obligation to support the legal, safe, and effective measures that were necessary to combat just such horrors. The role assigned to medical personnel combined the societal obligation with a responsibility for patient well-being.[144] The medical presence reflected a government commitment to the fundamental well-being of the detainee, while not allowing this commitment to preclude the acquisition of important, time-perishable intelligence not otherwise obtainable. The limits medical personnel set, and interventions made, allowed for the acquisition of the greatest possible information without placing the detainee at medical risk. In combination with RDG's tightly circumscribed policies on coercive measures, medical monitoring spared almost all detainees from experiencing more than a very time-limited period of discomfort.

In the continued ethical reiterations of 2005, some tacit acknowledgement of the societal obligation occasionally was implied, but only to be immediately discounted because some empirical "evidence" eliminated any potential ethical conflict. Both ethicists and the press regularly asserted that coercive measures were ineffective if not counterproductive, and produced serious and long-lasting physical and psychological aftereffects. More pointedly, the presence of medical personnel during interrogations was said to embolden the interrogators and lessen their restraints, thus placing interrogates at greater, not lesser risk. At worst, any physician present risked being co-opted, or socialized into a Nazi mentality.[145]

However much such "facts" simplified the ethicist's case, the OMS empirical experience was just the opposite. Invaluable intelligence resulted, medical and psychological aftereffects were not evident, and the presence of medical personnel unquestionably moderated interrogations and led to more benign interrogation guidelines. Medical autonomy also was preserved, with OMS personnel answering professionally only to OMS. Medical personnel were allowed to provide care to detainees even under

[144] Analogous dual physician roles are seen in forensic psychiatry, and occupational and public health, in which the public good sometimes overrides patient preferences.
[145] Rubenstein et al, "Coercive U.S. Interrogation Policies."

interrogation, in a professional and humane manner; and no one ever was asked to use medical expertise against a detainee, or to withhold treatment.

Finally, the carefully managed, selectively targeted Agency approach to interrogation had almost nothing in common with the excesses, program laxity, and indiscriminate focus alleged at Abu Ghraib and Guantánamo. From the outset, the RDG program was tightly circumscribed and carefully monitored, and quickly corrected problems encountered in the formative months. Almost from the outset, all interrogators, debriefers, guards, and medical personnel were prescreened, trained, guided both orally and in writing, and then monitored throughout their involvement with detainees. Despite its press image, this was a very carefully controlled program.

Program details—beyond that asserted in the media—were, of course, unknown to medical ethicists, but even with a more accurate understanding they likely would have reached the same conclusions. This was not necessarily the OMS expectation when the first medical ethics articles appeared in 2004. Unaware just how disproportionate had become the ethicists' commitments to the patient vis-a-vis society, there was some passing frustration at the mindset that casually equated mild to modest measures (e.g., limited sleep deprivation, or feeding through an NG tube) with sadistic, potentially lethal physical violence. All were torture or tantamount to it.[146] Much more useful would have been thoughtful, medically informed recommendations to help balance the acceptable degrees of coercion against the immediacy and gravity of an avoidable terrorist threat.

Ethicist views were anchored in "international" and "humanitarian" legal standards and professional declarations dating to the mid-1970s. Until the Administration's 2002 determination that al-Qa'ida terrorists were not legal combatants and thus not protected by Geneva Conventions, Common Article 3 of the Geneva Conventions provided a solid legal cornerstone for the ethicist position. Common Article 3 prohibited "at any time and in any place whatsoever: violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; outrages upon personal dignity, in particular humiliating and degrading treatment." A prohibition against cruel, humiliating or degrading treatment, or outrages on personal dignity could be and were used to cover a very wide range of interrogation measures.

Absent Common Article 3, there still was the UN Convention Against Torture, which as ratified by the U.S. barred the "intentional infliction of severe physical or mental pain and suffering." This was a much higher threshold, more genuinely consistent with what popularly would have been deemed torture. However, this too had been further circumscribed by DoJ's determination that "severe" pain was akin to that accompanying serious physical injury or organ failure, and that severe mental harm must last "months or years."

[146] Medical ethicists and the critical press were not the only ones to take this view. Even some who advocated the use of what the Agency viewed as coercive interrogation referred to it as justifiable "torture."

Further, along with railing at the Administration's permissive interpretations and asserting a humanitarian obligation to follow the Geneva Accords even if they were not legally binding, ethicists turned to another potentially valuable ally to carry their case—the professional associations of organized medicine.

The acknowledged foundational guidance on physicians and interrogation was issued in 1975 by the World Medical Association (WMA)[147] in response to questions about physician responsibilities in coercive interrogations of Northern Ireland militants. The WMA's "Declaration of Tokyo" held that physicians should not "countenance, condone or participate in the practice of torture[148] or other forms of cruel, inhuman or degrading procedures," nor "provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment." Doctors were not to be present "during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened." In short, "the doctor's fundamental role is to alleviate the distress of his or her fellow-men, and no motive whether personal, collective or political shall prevail against this higher purpose." The WMA reissued this declaration in both 2005 and 2006—after the extensive press reports of 2004-2005—adding a new section stating that physicians should 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" (emphasis added).

In 2005 the American Psychological Association also addressed "Psychological Ethics and National Security," partially in response to accusations of unethical behavior by Behavioral Science Consultation Teams (BSCT, or "biscuits") at Guantánamo Bay. These teams were comprised of a psychiatrist, a psychologist, and a medical assistant, who sought to bring the insights of behavioral science to the interrogation process. Allegedly they had used medical records to devise interrogation strategies. The APA (psychologist), without addressing any specific allegation, enumerated the "ethical obligations in national security-related work." More nuanced than guidance soon issued by medical organizations, this advised that psychologists:

--should not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment;
--do not use health care related information from an individual's medical record "to the detriment of the individual's safety and well-being";
--do not engage in behavior that violates U.S. law and may refuse for ethical

[147] The WMA was established immediately after World War II to address issues of international concern. The American Medical Association was one of many founders.
[148] Torture was defined by the WMA as "the deliberate, systematic or wanton infliction of physical or mental suffering…to force another person to yield information, to make a confession, or for any other reason."

reasons to follow laws that are unjust or that violate basic principles of human rights [but if a conflict results, they "may adhere to the requirements of the law"]

--"are sensitive to the problems inherent in mixing potentially inconsistent roles such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships"

--"may serve in various national security-related roles, such as a consultant to an interrogation, in a manner that is consistent with the Ethics Code, and when so doing…are mindful…of contexts that require special ethical consideration."

The following year an August 2006 APA resolution aligned the APA position more specifically with the United Nations Convention Against Torture, and the McCain Amendment (see following sections), but added no additional specificity to the guidance.

The American *Psychiatric* Association, though concerned over the 2005 Guantánamo reports, did not issue its own guidance for another year. In May 2006, this APA (psychiatrist) issued a "Position Statement" on "Psychiatric Participation in Interrogation of Detainees," which stated that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture." It continued, in part:

"…No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel 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."

Until mid-2007 OMS psychologists, given the legality of Agency practices (reaffirmed by DoJ in March 2005), saw themselves as working within the APA (psychologist) guidelines. OMS psychiatrists never were asked to monitor interrogations, though not as a matter of policy. Initially, psychologists were more available and soon they were more experienced. The APA (psychiatrist) guidelines were the more restrictive of the two, but on careful reading might still have allowed a role similar to that actually performed by OMS psychologists.

The next issued, and more categorical guidance came from the American Medical Association: "Physicians must not conduct, directly participate in, or monitor an interrogation with an intent to intervene, because this undermines the physician's role as

healer." In a modest concession to the physician's societal obligations, the statement added, "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 right of individuals."[149]

Since medical licensure in the United States is the exclusive purview of state medical boards, professional organizations such as the AMA have no direct power to enforce their views. State boards act on ethics violations, however, so the policy statements of professional organizations do have a potential impact. Critics very early sought to bring about change at Guantánamo Bay by attacking the licensure of the supporting medical staffs. Soon after the role of BSCT teams was publicized, the *New York Times* reported that lawyers representing detainees were trying to gather doctor's names to bring ethics changes against them in their home states.[150] Failing in this effort, lawyers later targeted physician John Edmondson, commander of the Guantánamo Bay Naval Hospital. In July 2005, a complaint against Edmondson was filed with the California State Board of Medicine, which had issued his license. He was charged with "unprofessional" conduct, including having overseen the inappropriate sharing of medical data, refusal of treatment, and active and passive involvement in physical abuse. The Board declined to pursue the case on the grounds that it could take no action against a military physician practicing on a military base absent action first by the military. They also cited a recently released study by Army Surgeon General Kiley, which had not found evidence of any medical abuse of the detainees.[151]

A few weeks later—on the fourth anniversary of 9/11—131 Guantánamo Bay detainees began a hunger strike to protest the conditions of their detention and lack of due process. Of these, [redacted] were involuntarily fed through naso-gastric tubes, most compliantly and within their cells.[152] (Given the small proportion of strikers artificially fed, the Navy probably followed a protocol similar to that of OMS and the Bureau of Prisons.) Physicians for Human Rights strongly protested the forced feedings, which was

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[149] AMA Press release, 12 June 2006, "New AMA ethical policy opposes direct physician participation in interrogation." This position seems to reject the suggestion of some ethicists that "limit setting, as guardians of detainee health" might be an acceptable role for physicians in "legitimate interrogation." See Bloche and Marks, "When Doctors Go to War."

The only other professional association to issue medical ethical guidance on interrogations was the American Academy of Physician Assistants (AAPA). This guidance was the most sparse. In 1987 the AAPA adopted statements opposing "participation of physician assistants in…torture or inhuman treatment," and endorsing "the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians and, by nature of their dependent relationship, for physician assistants, in cases of torture or other cruel, inhuman or degrading treatment or punishment in relation to detention or imprisonment." Most recently these AAPA statements were reaffirmed in 2003.

[150] "Psychologists Warned on Role in Detention," *New York Times*, 6 July 2004.

[151] "Head of hospital at Guantanamo faces complaint," *New York Times*, 15 July 2005; "Lawyers will appeal ruling that cleared Guantanamo doctor of ethics violations," *BMJ* 331:180, 23 July 2005. An appeal to the Board also failed.

[152] Susan Okie, "Glimpses of Guantanamo—Medical Ethics and the War on Terror." By mid-October the number of strikers was down to 25.

counter to both the WMA and AMA codes of ethics and which allowed a prisoner to starve himself to death.[153] Detainee lawyers used this episode to resume their challenge to Dr. Edmondson's licensure, and in January 2006 unsuccessfully argued to a California court that in view of the forced feedings the court should compel the state medical board to act.[154]

OMS viewed state licensing board action as a potential risk. The fact of a medical presence in the Agency program was easily discerned. Almost from the beginning there had been recurring charges that Agency medical personnel withheld pain medicine from AZ, drugged some detainees during transfer, and force fed al-Masri. The first substantial discussion of this issue, however, did not come until after the fourteen remaining HVDs were transferred to Guantánamo Bay in September 2006. The ICRC interviewed all fourteen, who comprised the most important al-Qa'ida operatives captured to date and had been those most aggressively interrogated.

The detainees appear to have given the ICRC a generally accurate summary of their overall experience (albeit recalling some traumatic episodes as lasting longer than they did). Enough medical information was included for the resulting ICRC report to include a section on "Health Provision and the Role of Medical Staff." This noted the provision of medical examinations on arrival, during interrogation, and during the long subsequent detention. Treatment provided was deemed "appropriate and satisfactory," with a comment that "in two specific instances…exceptional lengths were taken to provide very high standards of medical intervention."[155] The overriding issue, however, was the medical presence during the interrogation process, a presence correctly inferred from the use of a pulse oximeter during KSM's waterboard sessions, the repeated measurement of leg circumference during standing sleep deprivation, and detainee reports that medical personnel checked them during interrogations and sometimes intervened to stop the process.

[153] In 1991, the WMA position was modified to allow the option of physician intervention once the patient became confused or lapsed into coma, but both the Bureau of Prisons and the physicians at Guantánamo Bay act far before this stage is reached. In 2006 the WMA issued a lengthy further revision of its policy statement, which concluded: "Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment." Moreover, "[i]f a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding,….[he or she] should refer the hunger striker to another physician who is willing to abide by the…refusal." World Medical Association Declaration on Hunger Strikers, as revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006.

[154] *Jurist*, 8 January 2008; for fuller coverage, The Observer, 8 January 2006, on Guardian Unlimited, accessed at http://observer.guardian.co.uk/world/story/0,16937,1681736,00.html,. Subsequently, a British activist physician again filed this same charge against Edmondson with the medical boards of the states of California and Georgia. See "Force feeding at Guantanamo breaches ethics, doctors say," *BMJ* 332:569 (11 March 2006).

[155] "ICRC Report on the Treatment of Fourteen 'High Value Detainees' in CIA Custody," February 2007.

Labeling Agency interrogations ill-treatment tantamount to torture, the ICRC judged that the Agency program did not qualify as a "lawful interrogation, [in which] a physician may be asked to provide a medical opinion, within the usual bounds of medical confidentiality, as to whether existing mental or physical health problems would preclude an individual from being questioned," or "requested to provide medical treatment to a person suffering a medical emergency during questioning." Rather, medical personnel were "ruling on the permissibility…of physical or psychological ill-treatment." Their conclusion, therefore, was that:

> "….the interrogation process is contrary to international law and the participation of health personnel in such a process is contrary to international standards of medical ethics. In the case of the alleged participation of health personnel in the detention and interrogation of the fourteen detainees, their primary purpose appears to have been to serve the interrogation process, and not the patient. Is so doing the health personnel have condoned, and participated in ill-treatment."

Like many human rights and professional medical organizations, the ICRC held the traditional formulaic view that there were three controlling principles in medical ethics: act always in the best interest of the patient, do no harm to the patient, and insure the patient's right to dignity. Had OMS assessed itself against these criteria, it would have said that during the entire post-interrogation phase of detention these principles were honored. Excepting only a handful of involuntary feedings, consent was obtained before all medical procedures or they were not undertaken.[156] During the Agency's legally-sanction interrogations, however, the preservation of detainee dignity and "best interest" would have defeated the process, at the cost of innocent lives. Given the magnitude of the perceived terrorist threat, short periods of indignity and significant but medically safe discomfort (far short of serious, much less severe pain) seemed an ethically inconsequential price to pay to obtain the cooperation necessary to save lives. OMS nonetheless still was able to insure that no harm befell detainees while fulfilling a societal obligation that otherwise would have been impossible. There never was any question that, forced to make a choice, the preservation of lives would override the preservation of dignity.

[156] Tube feeding, while involuntary, was never forced, as the detainees always cooperated with the procedure. An intake physical examination, including appropriate blood work, also was mandatory, but after the interrogation phase detainees could decline physical exams (or elements of the exam) or laboratory studies, though almost none did. Concurrence was obtained in writing for all invasive procedures. There sometimes was a certain incongruity in asking a detainee for consent. At one point Nashiri, who at the time was manacled and closely attended by guards (because of recent acting out), laughed when the attending dentist asked his permission to pull a problem tooth: "You obviously can do anything you want," Nashiri noted. But he did give his consent.

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Notably, the ICRC's report on the fourteen detainees was not immediately leaked to the press.[157] The record to date suggests that this eventually will happen, at which time advocacy groups probably will attempt to attack the licensure of some OMS physicians. There are several reasons to believe that most if not all state medical boards would deal with ethics charges much as had California:

--DoJ had provided legal sanction to the program
--the C.I.A. (like DoD) would strongly assert the legal, ethical, and appropriately circumscribed role of the medical staff
--specific individual medical responsibilities likely would remain classified
--Bureau of Prisons policy and medical personnel would be similarly implicated
--even were existing medical ethical guidance relevant, it was sufficiently imprecise that it had to be clarified in 2006, after which no enhanced interrogations took place.[158]

A greater problem than licensure per se may be the legal and professional harassment of activists hoping to end an unpopular program by driving away its medical support, in essence exploiting the government's commitment to insuring that detainees are not harmed.

In August 2007, the American Psychological Association revisited their 2005 and 2006 statements on psychologist support to interrogations, and issued much more explicit and categorical guidance. This included an "absolute prohibition for psychologists against direct or indirect participation in interrogations or in any other detainee-related operations" involving a lengthy list of techniques alleged in media reports. Most relevant were hooding, forced nakedness, stress positions, slapping or shaking, and "sensory deprivation and over-stimulation and/or sleep deprivation used in a manner that represents significant pain or suffering or in a manner that a reasonable person would judge to cause lasting harm."[159] A movement to bar psychologists altogether from interrogation facilities was not successful. By the time this was issued (see following sections), the only clearly relevant item was slapping, though standing sleep deprivation would probably have been controversial.

More problematic than barring psychologist involvement in the prohibited techniques was a requirement that APA members report any psychologist who has

[157] In spring 2007, DCIA Hayden was asked to address Congressional Oversight Committees on various charges contained in the ICRC report. In these Hayden categorically denied any medical role other than monitoring the well-being of the detainees and providing treatment when indicated.
[158] APA (psychologist) guidance was less restrictive, but even so only one such interrogation took place after it released new guidance in 2005.
[159] "Reaffirmation of the American Psychological Association Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined in the United States Code as 'Enemy Combatants,'" Resolution Adopted by APA on August 19, 2007. Among the dozen or more enumerated techniques were waterboarding, hypothermia, exposure to extreme heat or cold, and exploitation of phobias or other psychopathology.



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participates in these techniques to the APA Ethics Committee, who in turn could revoke memberships and potentially jeopardize state licensure.[160] This, in essence, placed Agency psychologists in the same potentially vulnerable position as Agency physicians.



[160] "APA Rules on Interrogation Abuse," *Washington Post*, 20 August 2007; Eve Conant, "Capital Sources: Shrinks and Torture," *Newsweek* "Web Exclusive," 20 August 2007.

*An Unfinished Chapter*

The new DoJ policy statement on torture issued in December 2004 stated that it did not invalidate previous guidance on specific interrogation techniques. DoJ's long-awaited re-evaluation of these techniques finally was forwarded to the Agency in May 2005. Three separate memoranda were sent, all reflecting an understanding of Agency practice and experience not available in 2002—as well as insights gleaned from the voluntary waterboarding of a senior DoJ lawyer.

A foundational 10 May 2005 memoranda corrected and expanded the 2002 descriptions, then reaffirmed that the previously addressed techniques fell short of torture.[161] These were three conditioning techniques (dietary manipulation, nudity at ambient temperature of at least 68°, and sleep deprivation), five corrective techniques (attention grasp, facial hold, facial or insult slap, abdominal slap, and walling), and four coercive techniques (stress positions, water dousing, cramped confinement, and waterboard). A second 10 May 2005 memorandum expressly extended this conclusion to the combined use of these techniques.[162] The final memorandum, dated 30 May 2005, responded to an Agency IG concern in affirming that these techniques were not barred by Article 16 of the Convention Against Torture, as ratified. This barred "cruel, unusual, and inhumane treatment or punishment prohibited by the Fifth, Eighth, and Fourteenth Amendments to the Constitution." As interpreted the Fifth Amendment was of greatest relevance, and the Supreme Court standard against which treatment was to be measured was whether a techique "is so egregious, so outrageous, that it may fairly be said to shock the contemporary conscience," a judgment noted by the Court to be highly context-specific and fact-dependent.[163]

New to the 2005 guidance was an extraordinary reliance on OMS input, totally absent in 2002. The Agency General Counsel, during an early 2004 visit, had mentioned that OMS involvement now was central to the Agency's legal case. Just how important became clearer in summer OMS-DoJ discussions during which C/MS finally observed that DoJ seemed to be under the misimpression that this was an OMS program—rather than OMS supporting CTC/RDG. In acknowledging an overemphasis, DoJ nonetheless said the presence of OMS was critical to their determinations. OMS thereafter tried to remain alert to any transformation from the notion that the RDG program being acceptable in part because of OMS involvement into something that sounded more like

[161] Steven Bradbury (DoJ/OLC) to John A Rizzo, Senior Deputy General Counsel, Central Intelligence Agency "Re: Application of 18 U.S.C. 2340-2340A to Certain Techniques That May Be Used in the Interrogation of a High Value al Qaeda Detainee," 10 May 2005.
[162] "Memorandum for John Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, "Re: Application of 18 U.S.C. 2340-2340A to the Combined Use of Certain Techniques in the Interrogation of High Value al Qaeda Detainees," 10 May 2005.
[163] Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency "Re: Application of United States Obligations Under Article 16 of the Convention Against Torture to Certain Techniques that May Be Used in the Interrogation of High Value al Qaeda Detainees," 30 May 2005.

the program being acceptable because OMS said it was. The only OMS role, if and when Justice determined that any given technique was legal, was to insure the safety of the detainee—a responsibility as well shared by interrogators and other staff.

The final DoJ memoranda stated that the legitimacy of the RDG program hinged on several-OMS relevant factors: OMS autonomy within the program; OMS assurance that detainees would be adequately evaluated—physically and psychologically—prior to, during, and following any enhanced interrogations; the authority of OMS to stop or otherwise limit any ongoing interrogation, if medically indicated; and the OMS experience that to date no medically significant aftereffects had been apparent in any previously interrogated detainee. A reliance on OMS was underscored by the inclusion of multiple quotations incorporated from the latest (December 2004) issuance of OMS Guidelines, and by many references to discussions with OMS personnel. An illustrative excerpt, from the 10 May 2005 memoranda addressing interrogation techniques:

> "In addition, the involvement of medical and psychological personnel in the adaptation and application of the established SERE techniques is particularly noteworthy for purposes of our analysis. Medical personnel have been involved in imposing limitations on—and requiring changes to—certain procedures, particularly the use of the waterboard. We have had extensive meetings with the medical personnel involved in monitoring the use of these techniques. It is clear that they have carefully worked to ensure that the techniques do not result in severe physical or mental pain or suffering to the detainees. ... In addition, they regularly assess both the medical literature and the experience with detainees. [FN To assist in monitoring experience with the detainees, we understand that there is regular reporting on medical and psychological experience with the use of these techniques on detainees and that there are special instructions on documenting experience with sleep deprivation and the waterboard.] OMS has specifically declared that "[m]edical officers must remain cognizant at all times of their obligation to prevent "severe physical pain or suffering" [citation omitted]. In fact, we understand that medical and psychological personnel have discontinued the use of techniques as to a particular detainee when they believed he might suffer such pain or suffering, and in certain instances, OMS medical personnel have not cleared certain detainees for some—or any—techniques based on the initial medical and psychological assessments. They have also imposed additional restrictions on the use of techniques (such as the waterboard), in order to protect the safety of detainees, thus reducing further the risk of severe pain or suffering. You [i.e., the Agency] have informed us that they will continue to have this role and authority. We assume that all interrogators understand the important role and authority of OMS personnel and will cooperate with OMS in the exercise of these duties...."

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Read in totality, the final DoJ guidance made clear that the OMS role was supportive, but this lengthy paragraph still was potentially misleading, in citing the "involvement of medical and psychological personnel in the adaptation and application of the established SERE techniques." The only OMS role in the adaptation or application of SERE techniques was to place medical restrictions on the use of the techniques selected and authorized independently of OMS.

Following the summer 2004 press accounts, and prior to these DoJ memoranda, Senators John McCain (R-Ariz) and Lieberman (D-Conn) put language into an intelligence bill which barred "torture or cruel, inhuman, or degrading treatment or punishment that is prohibited by the Constitution, laws or treaties of the United States," and required a report to Congress on interrogation measures. In January, at Administration urging, this language was dropped. That spring, 2005, Democrats and Republicans debated the need for a probe of interrogation practices, but no probe resulted.

In October 2005, Senator McCain introduced an amendment to a Defense appropriation bill which again barred "cruel, inhuman, or degrading treatment or punishment"—defined as any "cruel, unusual, and inhumane treatment or punishment" prohibited by the Fifth, Eighth, and Fourteenth Amendments (applying to non-US citizens what otherwise would have pertained only to U.S. citizens). Kerry also attached an amendment to the Senate Intelligence Authorization bill requiring a report on the Agency's recently publicized Eastern European and Asian detention facilities. Ultimately both Kerry amendments failed, but the McCain amendment moved forward—ultimately without an Agency exemption sought by Vice President Cheney and DCIA Porter Goss.

The McCain amendment—subsequently known as the Detainee Treatment Act (DTA)—passed both House and Senate by large margins, and in December 2005 was signed into law. The implications of the DTA proved somewhat more limited than expected. DoJ already had ruled that Agency techniques did not reach the threshold for the "cruel, inhuman, or degrading" treatments barred by the Constitution, and a new DTA requirement that DoD interrogation guidelines be followed was applicable only to DoD facilities, and not to "secret" Agency sites. Less reassuring was the way the DTA addressed the question of legal protections for those engaged in authorized interrogations. This stated that the U.S. Government "may" pay employee costs (including legal counsel) associated with civil action or criminal prosecution, and offered as an employable defense that "a person of ordinary sense and understanding would not know the practices were unlawful."

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Over several months in the spring and summer of 2006 an OMS physician escorted five detainees that required specialized evaluation or surgery to received this care. Additionally, during this period a concerted effort was made to move as many detainees as possible out of Agency hands; of the still in RDG facilities in late February, half had been transferred elsewhere by September, with most returned to their countries of origin. As previously, OMS personnel accompanied all detainee movements.

In June, 2006, the Supreme Court ruled in *Hamden v. Rumsfeld* that the military commission system then in place at Guantánamo Bay was not legally authorized. Additionally, the Court stated that the provisions of Common Article 3 of the Geneva Conventions (on the treatment of prisoners of war) was applicable to detainees. In response to this ruling, the Administration introduced legislation that became the Military Commission Act (MCA) of 2006 (signed in October).

The MCA established a new system of military tribunals and, consistent with Common Article 3, amended the War Crimes Act of 1996 to bar not just techniques that caused "severe physical or mental pain or suffering" ("torture"), but also those which caused "severe or serious physical or mental pain or suffering" (or "cruel or inhuman treatment"). No specific techniques were addressed; rather, the President was given authority to more specifically interpret the implications of the Common Article 3 through an Executive Order.

Finally, the MCA strengthened the protections extended by the DTA to those involved in authorized interrogations prior to 30 December 2005. Employee costs incurred during any investigation or prosecution—in the U.S., abroad, or in international tribunals—would be paid by the U.S. government.

During the summer 2006, a White House decision was made to transfer to military custody at Guantánamo Bay the 14 HVDs (b)(1) (b)(3) NatSecAct

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With the transfer of the 14 detainees to Guantánamo,

Within a few months, a newly captured detainee was transferred Abdul Hadi al Iraqi, the designated replacement for Zarqawi as head of al-Qa'ida operations in Iraq. He had read of CIA interrogation methods, he said, and preferred just to cooperate without them. Whether or not he was truly forthcoming is unclear, but no enhanced interrogation methods were employed prior to his transfer to Guantánamo Bay in April 2007.

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There they were allowed to talk with one another, some for the first time in several years, and also were interviewed by the ICRC. Each was assigned a military lawyer to help prepare for a tribunal hearing on their status as illegal combatants. Were this status established, they then faced prosecution for their terrorist acts.

To date the Agency program had passed through two almost discrete phases. The first period, from 2002 through 2004, was primarily one of multiple successful interrogations. The second period, from 2005 through 2006, was one of lengthening detentions. The character of any third period is—as of summer 2007—still uncertain. While the Agency suspended use of EITs following the December 2005 enactment of the DTA, it did not abandon the notion of playing a unique role in the interrogation of HVDs. After reviewing the overall program, the Agency sent DoJ a request to evaluate a much reduced set of proposed "enhanced" techniques, which did *not* include walling, the waterboard, confinement boxes, dousing, and stress positions. The proposed array of techniques was limited to the three established conditioning techniques: nudity, dietary manipulation, and sleep deprivation; and four of the five corrective techniques approved in 2005: facial grasp, attention grasp, abdominal slap, and facial or insult slap (but not walling). No coercive measures were included.[164] The proposed upper limit on sleep deprivation remained at 180 hours, but with a new requirement that the detainee be reassessed after 96 hours and specifically re-approved for each additional 24 hours.

OMS welcomed these changes as further limiting medical risks without appreciably weakening program effectiveness. In its view, interrogation success appeared to result primarily from the three "conditioning" techniques proposed for

[164] In contrast to the reality, a *Newsweek* "WEB EXCLUSIVE," 20 September 2005, cited Senate staffers as saying the Administration were trying to redefine the Geneva limitations to allow seven techniques: 1) induced hypothermia, 2) long periods of forced standing, 3) sleep deprivation, 4) the "attention grab" (forcefully seizing the suspect's shirt), 5) the "attention slap," 6) the "belly slap" and 7) sound and light manipulation.

retention, particularly sleep deprivation.[165] Since to date only three detainees had been kept awake beyond 96 hours (and none as long as 180 hours), the proposal was entirely consistent with ongoing practice. "Corrective" techniques also appeared to play a synergistic role, but from the medical standpoint, walling was somewhat problematic because if not handled carefully could result in head contact with the wall. It also appeared less controlled than any other technique, and infrequently required some medical intervention.[166] Elimination of all coercive measures, and walling, would appreciably simplify medical monitoring.

As previously, OMS was brought into these newest DoJ discussions, this time in the hope that a medical distinction was possible between "severe" and "serious" physical and mental suffering. Thinking this an entirely legal question, OMS declined to speculate. Ultimately, a provisional DoJ analysis found all the requested techniques legally acceptable, i.e., they did not reach the threshold of "serious" pain or suffering. A definitive ruling awaited the underlying Executive Order interpreting Common Article 3. OMS also contributed to this discussion, through a briefing for DNI Admiral Mike McConnell on medical support to the interrogation and detention program.

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The President's Executive Order finally was released in mid-July 2007, prompted by the desire to interrogate a key al-Qa'ida operative, recently captured and rendered [redacted] This EO interpreted Common Article 3 as requiring "the basic necessities of life, including adequate food and water, shelter from the elements, necessary clothing, protection from extremes of heat and cold, and essential medical care." Barred were torture or other acts comparable to murder, torture, mutilation, cruel and inhuman treatment, or acts of abuse or degradation what a reasonable person would deem "beyond the bounds of human decency." Beyond these limits, enhanced measures were still allowable, as was detention without outside access. [NEED TEXT]

The Justice Department immediately followed this with concrete guidance largely unchanged from that agreed to in draft, and allowing sleep deprivation (as above), dietary manipulation, and the several requested slaps and holds. Only nudity had been changed—to diapering.

Asked about the Executive Order on NBC's "Meet the Press," Director of National Intelligence (DNI) Mike McConnell would not say exactly what would be permitted, but he did highlight—as never publicly before—the medical role in the process:

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[166] On two occasions detainees complained of potentially walling-associated memory or hearing loss, but a detailed evaluation at the time found both to be feigned symptoms.

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"…When I was in a situation where I had to sign off, as a member of the process, my name to this executive order, I sat down with those who had been trained to do it, the doctors who monitor it, understanding that no one is subjected to torture. They're, they're treated in a way that they have adequate diet, not exposed to heat or cold. They're not abused in any way. But I did understand, when exposed to the techniques, how they work and why they work, all under medical supervision."[167]

(At the time of this writing—September 2007—the only candidate to be interrogated under these new guidelines alleged the unusual combination of visual and auditory hallucinations after just over 100 hours of standing sleep deprivation. As a result, he was allowed a 16-hour sleep break, but continued to claim visual hallucinations. A thorough psychological examination at that time led to the conclusion that he was malingering. He was returned to intermittent sleep deprivation, up to the 180 limit [over 30 days], but this did not achieve compliance with interrogators.)



[167] Transcript, Mike McConnell interview on "Meet the Press," Tim Russert, Anchor, MSNBC.com, 22 July 2007. The possible interpretation that physicians were supervising the enhanced interrogations later was addressed briefly by a McConnell spokesman who clarified that McConnell said that doctors would "monitor, not supervise" interrogations, but would not clarify if this referred to physicians, or how the monitoring would be accomplished, or if this was a new requirement. Spencer Ackerman, "(Re)Call the Doctor: Physicians Involved in CIA Interrogations?," TPMMuckracker.com, 23 July 2007. Russert, like many others, wanted to know what techniques could and could not be used (especially the waterboard), but McConnell—like other Administration spokesmen—refused to specify on the grounds that this would allow training against the techniques, and "because they believe these techniques might involve torture and they don't understand them, they tend to speak to us, talk to us in very—a very candid way."

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Support to the RDG program may well be the most extensive operational commitment in the history of the Office of Medical Services. It certainly was one of the most intense. During the five years from 2002 to 2007, [redacted] OMS staff officers [redacted] (b)(3) CIAAct physicians, [redacted] psychologists, [redacted] PA's, and [redacted] nurses) were directly involved in the program. These officers evaluated, monitored and provided quality care to 97 detainees variously held in ten Agency facilities. They also accompanied well over a hundred detainee transfer flights. Their guidance and presence made possible one of the most successful counter-terrorist operations in the history of the Agency.

An enumeration of the intelligence take from the dramatically successful RDG program is beyond the scope of this history. Over 8,000 intelligence reports were generated, which was half or more of all al-Qa'ida reporting during the period. Detainee-provided information led directly to the capture of other key terrorists, averted several major terrorist attacks, and became a foundation for the 9/11 postmortem analysis. Even in the face of crippling media leaks and widespread public criticism, the Agency (and Administration) remained unwilling to abandon what had proven an invaluable tool.

Whether a more circumscribed future program will prove similarly valuable remains to be seen. Even with a retained core of less aggressive but seemingly effective techniques, this may not be possible. Eventually the Administration will be pressed to state publicly that certain aggressive measures will not be used (thereby reassuring future detainees, to the detriment of the process). Crippling leaks will remain inevitable, and approved techniques—however benign—eventually will become known and again be targeted by human rights activists. This could easily lead to the elimination of all the synergistic adjuncts to sleep deprivation, and so limit sleep restriction that it rarely is effective. Additionally, publicity to date will have led to the development of effective resistance measures.[168] In short, the immediate prospects do not look promising. Taking a longer view, future terrorist use of WMDs is viewed as inevitable; and such an attack would likely lead to another reevaluation of what interrogation measures are acceptable.

When OMS again is approached on this subject, this brief history may be of some value. A few points may be worth repeating. As OMS began this chapter, it could find no comparable record of the somewhat related experiences of the Fifties, which would have been useful. Organizationally, OMS was somewhat buried at the time in a short-lived but distracting realignment with Human Resources. Operational requests regularly were addressed, but outside the paramilitary environment OMS was not then aggressively attempting to insert itself into operations. Thus, when OTS formulated its approach to detainee interrogation, there was no meaningful medical input or review—and

[168] E.g., effective countermeasures against such techniques as standing sleep deprivation were discussed within the Agency as early as the 1950s, and simply capitalize on the desire of interrogators not to inflict serious of lasting harm. Deliberate "collapse" or a sophisticated but feigned hallucination will almost guarantee a reprieve which likely will defeat the interrogation process as used to date.

interrogational excesses resulted. In hindsight it's easy—though in the operational climate, perhaps unrealistic—to say that OMS should have been more pro-active in obtaining and critiquing the relevant briefs. Once into this fast-moving program, OMS also fell short in allowing a requirement for thorough medical records to fall victim to operational expediency and the crisis of the day. While this soon was corrected, it also was avoidable. Finally, as OMS increasingly was recognized for its vital contributions, there seemed to be a risk that too much of the program's legal justification would become OMS-based. While this issue was attended to, in view of the unique ethical issues involved it was a source of continuing concern

A last word on ethics. The more proscriptive stands taken by professional organizations since 2006 will pose potential dilemmas for OMS professionals supporting detainee operations in the future. The OMS officers who previously worked in this program confronted less concrete "ethical" issues, but nonetheless involved themselves because they thought it was the right thing to do, and because of their trust and respect for those already involved. [redacted]MS may have been representative in viewing the legitimacy—i.e., ethics—of the program as dependent on it being legal, effective, safe and necessary. Necessity required solid evidence that interrogation candidates possessed critical, time-perishable information unobtainable through less aggressive alternative measures. DoJ affirmed legality. The empirical record affirmed effectiveness and, through the presence of OMS, the safety of the program. Finally, criticality and urgency each received case-by-case analysis from CTC. Though imperfect this review nonetheless limited the application of EITs to less than a third of the 97 detainees who came into Agency hands, and further limited use of the most aggressive techniques to only 5 or 6 of the highest value detainees. A criterion of "necessity" also requires that no aggressive measure be used when a lesser measure would suffice. For a variety of reasons, the program initially was ill-prepared to make this judgment, but experiences during the first year had it well on its way to a minimalist approach.

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