Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees

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SECRECY HAS RESTRICTED SCRUTINY OF THE ROLE OF PHYsicians and other medical personnel in the Central Intelligence Agency's (CIA's) "enhanced" interrogation program, begun in 2002. The program, also labeled "physical and psychological pressure," was designed to "psychologically 'dislocate' the detainee, maximize his feelings of vulnerability and helplessness, and reduce or eliminate his will to resist" efforts to obtain intelligence.[1-3(appendix F)] In 2009, the Obama Administration released guidelines on enhanced interrogation written in 2003 and 2004 by the CIA Office of Medical Services (OMS).[1-3(appendix F)] The OMS guidelines, even in redacted form, and opinions from the US Department of Justice's (DOJ's) Office of Legal Counsel show that CIA physicians, psychologists, and other health care personnel had important roles in enhanced interrogation.

Enhanced interrogation methods were applied in escalating fashion. Interrogators typically began by removing the detainee's clothes, limiting food, and depriving him of sleep through the use of stress positions. If this failed to produce intelligence, interrogators introduced "corrective" and "coercive" methods, including facial and abdominal slaps, dousing with cold water, stress positions and wall standing, confinement in a small or large box, and "walling" (throwing a detainee against a wall up to 20-30 times).[4] If the detainee still did not provide information, interrogators could use waterboarding (simulated drowning).[4] These methods have been recognized to constitute torture under international and domestic law by inflicting severe physical or mental pain or anguish on a person.[5,6]

According to OMS guidelines, physicians and other health care professionals performed on-site medical evaluations before and during interrogation, and waterboarding required the presence of a physician.[1(p8)2(p9)3(appendix F, p2)] Exercising these functions violated the ethical standard that physicians may never use their medical skills to facilitate torture or be present when torture is taking place.[7] In 2003, partially in response to a CIA Inspector General investigation that questioned the use of enhanced interrogation methods and criticized the agency's failure to consult with OMS about the risks to detainees of waterboarding,[3] OMS physicians assumed another role, providing opinions to the agency and lawyers whether the techniques used would be expected to cause severe pain or suffering and thus constitute torture.[1,2,4,8] Physicians provided opinions on potential health effects of enhanced interrogation, described medical "limitations" on their use, and listed references.[1,2] The OMS analysis is summarized in part in an appendix to OMS guidelines issued in May 2004,[1] which are reproduced in the TABLE (these were slightly revised in December 2004).[2] In some cases, the guidelines also urged documentation of the effects of enhanced interrogations on detainees.[9] The guidelines recognized that waterboarding creates risks of drowning, hypothermia, aspiration pneumonia, or laryngospasm; cramped confinement could result in deep vein thrombosis; and death could result from lengthy exposure to cold water.[1,2]

The OMS approved these and other methods as long as "limitations" were in place.[1,2] These limitations included durational limits for exposure to a specified temperature, either up to the time hypothermia would be expected to develop or on evidence of hypothermia; body weight loss of 10% or evidence of significant malnutrition as a result of dietary restrictions; and exposure to noise just under the decibel levels associated with permanent hearing loss. Stress positions were permitted for up to 48 hours provided the detainee's hands were no higher than the head, weight was borne by lower extremities, and preexisting injuries were not aggravated. In addition, time limits for confinement in a box were specified (eg, 8 consecutive hours and 18 hours per day for the larger box). The OMS guidelines also advised that emergency resuscitation equipment be available when waterboarding was used. No medical limitations were imposed for walling.[1,2]

The OMS physicians also consulted directly with DOJ lawyers to support legal decisions that interrogators who applied enhanced interrogation methods neither inflicted nor intended to inflict severe mental or physical pain or anguish and thus did not commit torture.[4,8] Justice Department opinions note that OMS physicians assured the lawyers that sleep deprivation as used by the CIA would not lead to profound disruption in the detainee's senses or personality (the legal definition of psychological torture),[8(p39)] that there was no "medical reason" to believe that waterboarding leads to physical pain,[8(p42)] and that the combined use of enhanced interrogation methods would not cause severe pain.[4(p12)]

The OMS endorsement that these methods do not cause severe mental or physical pain or suffering is contrary to clinical experience and research.[5] The OMS failed to take account of pertinent medical and nonmedical literature about the severe adverse effects of enhanced methods, including the cumulative effects on prisoners subjected to practices such as sensory

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Table. Medical Rationales for Limitations on Physical Pressure[a]

Measure	Medical Limitation	Rationale for Limitation (References)[b]
Shaving	None	Standard hygiene measure in other custodial settings; risk of skin infections (none)
Stripping	Ambient air temperature minimum 64°F/18°C	Below this temperature hypothermia may develop (WHO guidelines)
Diapering	Evidence of loss of skin integrity due to contact with human waste materials	Diapering commonly employed in other care settings where incontinence is an issue (none)
Hooding	None [redacted]	Methodology used in SERE training [redacted][c]
Isolation	None	Methodology used in SERE, prison settings [redacted][c]
White noise	79 dB maximum	Prevention of permanent hearing damage (OSHA guidelines for continuous noise exposure) [redacted]
Continuous light or darkness	Related to sleep deprivation	Used in other settings [redacted]
Uncomfortably cool environment	<3 h below 60°F/16°C, with monitoring for development of hypothermia; use of water will further limit exposure time	Requires monitoring for development of hypothermia; risk is patient-specific (WHO guidelines; *Wilderness Medicine*, 4th ed, chap 6 and 9)
Restricted diet	Loss of 10% of body weight	10% Loss indicates significant malnutrition and requires corrective action (BOP guidelines)
Shackling in upright sitting or horizontal position	48 h standard; longer period requires medical monitoring	Prolonged standing likely to induce dependent edema, increased risk for DVT, cellulitis (CIA Counterterrorism Center [CTC] guidelines; experience with >20 detainees)
Water dousing	Cessation upon evidence of hypothermia; ambient temperature minimum 64°F/18°C; potable water source	1 h at 5°C; hypothermia can be induced in 30 min with 41°F/5°C water, 45 min with 54°F/10°C water, and 60 min with 59°F/15°C water immersion; immersion at temperatures below 77°F/25°C will eventually be fatal over time (*Wilderness Medicine*, 4th ed; Transport Canada, *Survival in Cold Waters*, 2007; PREAL operating instructions[d])
Sleep deprivation	48 h for standard; [redacted]	Periods of sleep deprivation >90 h have been shown to be safe and without long-term sequelae in large groups, and >200 h in individuals; required recuperative period undefined. Note 0.5°C drop in body temperature, which may impact use of water. Sleep deprivation does degrade cognitive performance, may induce visual disturbances, may reduce immune competence acutely. (CTC guidelines; Horne J, *Why We Sleep*; NIDHS/NIH Web site)
Attention grasp	Correct technique; no preexisting injury likely to be aggravated	[redacted]
Facial hold	Correct technique; no preexisting injury likely to be aggravated	[redacted]
Insult slap	Correct technique; no preexisting injury likely to be aggravated	[redacted]
Abdominal slap	Correct technique; no preexisting injury likely to be aggravated	[redacted]
Stress positions	Correct technique; no preexisting injury likely to be aggravated	[redacted] (PREAL operating instructions[d])
Walling	Correct technique; no preexisting injury likely to be aggravated	Risk of whiplash type injury; [redacted]
Cramped confinement	Correct technique; no preexisting injury likely to be aggravated	Attention to risks of immobilization, including DVT; ensure adequate air flow; ambient temperatures (PREAL operating instructions[d])
Waterboard	Correct technique; no preexisting injury likely to be aggravated; [redacted]; resuscitation capability immediately at hand; potable water source	Risks include drowning or near drowning; hypothermia from water exposure; aspiration pneumonia; laryngospasm (OMS guidelines)

[a] Reprinted (and reformatted for space) from *OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation and Detention*[1,2]; [b] Footnotes on abbreviations added by authors; [c] SERE indicates Survival, Evasion, Resistance and Escape, a training program used by the US military to prepare soldiers to withstand torture and other forms of abuse if captured by an enemy; [d] PREAL indicates *Pre-Academic Laboratory Operating Instructions Manual: Survival, Evasion Resistance and Escape Program*; May 7, 2002.

deprivation, sleep deprivation, waterboarding, and isolation.[5] The few sources OMS did cite were not derived from interrogation or detention programs but, at most, only established threshold exposure limits that would endanger survival or cause permanent physical injury.

This medical participation in enhanced interrogation represents a failure by the physicians involved, and by the OMS institutionally, to uphold ethical medical values. Indeed, OMS encouraged physicians at the CIA detention sites to support enhanced interrogation by reinterpreting the ethical standard. Even as it reminded physicians of their "obligation to do no harm," OMS limited that duty only to "prevent severe mental pain and suffering."[1,2] This breach extended beyond physicians who participated in interrogation to those at the policy level who gave a medical imprimatur to the use of enhanced interrogation, without which it is possible that the DOJ might have been more constrained in approving techniques that amounted to torture. The gravity of these violations demands further investigation, accountability, and reform.

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