A PANEL DISCUSSION ON:

“MEDICAL ETHICS IN THE AGE OF TERRORISM: THE ROLE OF MILITARY MEDICAL PROFESSIONALS IN INTERROGATIONS”

MODERATOR:

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DR. LAWRENCE J. KORB: Welcome to everybody. My name is Larry Korb and I have the honor of (a) welcoming you to this panel, and (b) chairing this panel on Medical Ethics in the Age of Terrorism: The Role of Military Medical Professionals in Interrogations.

We're very fortunate today with the panelists that we have. All of them are prolific authors. Our first two speakers are going to talk about some articles that they have written on this subject. All have real-world experience with these issues.

Now, before I introduce the panelists, I want to say two things. One, we asked the assistant secretary of defense for health affairs to send a representative. They declined. And we also asked that if Major General Lester Martinez-Lopez, M.D., who is the lead author of the Army’s assessment of detainee medical operations, if he could appear and they also turned it down, even though he is retired.

Now, despite that I think that we’re going to have a terrific, terrific discussion here. And as you know, the recent events of the bombings in London and the hunt for those responsible for the second wave of attacks have once again ignited the debate over what limits should be placed on the authorities in their efforts to protect all of us from terrorists. If you had a chance to look at the Washington Post today, you saw that this issue again has become front and center.

Now, there are indications that the administration has sought to push the envelope of authorized interrogation techniques in this war on terrorism and there is some evidence that U.S. military physicians, psychiatrists, and psychologists have used detainee medical records to capitalize on illness, phobias, and other vulnerabilities to devise strategies to elicit information from detainees. So the Center here is very happy to – and pleased to bring these experts together to discuss the role of military medical professionals in the interrogation process.

Our first speaker today will be Jonathan Marks, and those of you who had a chance to look at his biography, you’ll notice that he is a barrister. Now, I found out in talking to him the difference between a barrister and a lawyer is the barrister wears one of those wigs over in the United Kingdom. He holds a number of positions right now. He is a barrister at the Matrix Chambers in London, England, and a Greenwall Fellow in Bioethics, Health Law and Policy at Georgetown University Law Center and the Bloomberg School of Public Health at Johns Hopkins. But most importantly, he’s also a visiting fellow here at the Center for American Progress.

His colleague and co-author of the two papers that you have in the brochure that we handed out is Dr. Gregg Bloche, who is a professor of law at Georgetown University, a visiting fellow at the Brookings Institution, and with Jonathan the co-author of “When Doctors Go to War,” and “Doctors and Interrogators at Guantanamo Bay.”
Our third panelists will be Mr. Reuel Gerecht, who is a resident fellow at American Enterprise Institute. More importantly, he’s been a former Middle East specialist in the CIA and the author of a number of articles and books; most recently “Against Rendition” and “What’s the Matter with Gitmo?” that both appeared in the Weekly Standard. And if you watch any of the major network news, you’ll recognize his face.

Our final panelist is Dr. Stephen Xenakis, who is the director of child and adolescent psychiatry at the Psychiatric Institute of Washington. And before taking that position, he was the commanding general of the Southeast Regional Army Medical Command. He is the author of “From the Medics, Unhealthy Science,” in the Washington Post and he retired from the Army with the rank of brigadier general.

I’m going to ask Jonathan and Gregg if they would summarize their articles for us in about 15 minutes. Then I’m going to ask Reuel and Stephen to spend about 10 minutes commenting on it.

So Jonathan and Gregg, the floor is yours.

MR. JONATHAN MARKS: Thank you, Larry, for that kind introduction. Before I begin, I’d just also like to thank the Center for hosting this event, and in particular Ken Gude for taking such trouble to put it all together. Thanks, ken.

I’m – Gregg and I are just going to very briefly outline the role of physicians, psychologists, and other medical personnel in interrogation at Guantanamo Bay and Abu Ghraib and elsewhere. Then hopefully we can expand a little during the question and answer session.

The first thing, though, we’d like to make very clear is that by and large military medical personnel in the war on terror have done wonderful work, saving the lives of not just U.S. soldiers, but also wounded combatants on all sides, and in fact have historically reduced the ratio of wounded to killed in action, which is a great measure of their effectiveness in a conflict.

What we’re talking about today here is a very small subset of military medical personnel who have been involved in the interrogation mission. Our enquiry essentially pursues a number of questions. We ask, first, what did clinicians who were assisting in the interrogation mission actually do? How did their roles support post-9/11 interrogation strategies, and what were those strategies in fact? And we also then ask the important questions which follow from this: what are the legal and ethical implications of the participation of medical personnel in interrogation and these other practices?

Now, one of the first discoveries in our line of enquiry was a slideshow provided to the new arrivals at the Joint and Intelligence and Debriefing Center at Abu Ghraib Prison, which essentially outlined the history of the prison and explained the importance
of the interrogation mission. And this is one slide, which you can see, which says “The
database is lonely, you can help.” You can see it’s written by someone with a wry sense
of humor. “Visit the database every time you spend time with any of our esteemed
guests. The database wants to hear how things went with our friends who come to spend
quality time with our guests. Tell the database what fun conversation you and your guest
had, and then, of course, give the database more background.” And then you see that
rather comical, little, smiley face.

Again, towards the end of that presentation, there’s another slide – a little cartoon
of somebody holding a glove puppet and then the quotation underneath, which you
probably can’t read because it’s too small, but it says, ”I realize it sounds rather cliché,
but we have ways of making you talk.”

We discovered in the course of our enquiry, however, that the interrogation
process is slightly less humorous than that slide may suggest. We know that at
Guantanamo Bay, Abu Ghraib, and probably elsewhere, interrogators and/or behavioral
science personnel had access to medical records, which were created and kept by clinical
caregivers. The behavioral science personnel arranged in teams known colloquially as
BSCTs, were staffed by one or two psychologists or psychiatrists – and/or psychiatrists,
and their purpose was to develop psychological profiles on high priority detainees and to
advise the military intelligence tiger teams on how to conduct interrogation and counter-
resistance strategies.

Now these physicians, psychologists, and other health professionals were attached
to the military intelligence units in support of the interrogation mission. They were not
providing healthcare, but we have seen a number of unsubstantiated reports, indeed
detainees have alleged, that they were drugged in order to make them more compliant
during interrogation.

The psychiatrists and psychologists were a part of the vision of Major General
Geoffrey Miller, who ran the camp at Guantanamo Bay. He believed it was necessary to
fuse all prison functions in order to assist and support the interrogation mission. Now, in
his view, the behavioral science consultation teams were – in his words – “essential in
order to develop integrated interrogation strategies and assess interrogation intelligence
production.” And, as I said, the purpose was to develop these individualized
interrogation plans for high-priority detainees.

Now, in late 2002 and early 2003, Miller initially developed this approach at
Guantanamo Bay and then in summer of 2003, early fall of 2003, he brought a team to
Abu Ghraib – was rather upset at what he considered to be the ramshackle process there,
issued a scathing rebuke, and suggested that as the insurgency worsened it was all the
more important now that we have the same behavioral science approach to interrogation
in Abu Ghraib as had been developed at Guantanamo Bay.

And here is another slide from that slideshow I described to you. This was also a
poster which appeared on the walls of the interrogation center at Abu Ghraib, and you
can see on the left a number of interrogation techniques for which there is broad-blanket approval, including using techniques to provoke mild or harsh increases in detainee fear. And then you will see, on the right, further techniques which require the approval of the commanding general, who was Lieutenant General Ricardo Sanchez in Iraq. And you will see on the list there, for example, that dietary manipulation is one of these techniques which requires approval and that may be – that is to be monitored by a medic.

We’ve seen one or two of these requests that have been leaked to the press and they include also, for example, a request to throw chairs at detainees taking, quote, “all necessary precautions to avoid hitting the detainee and not to coerce him in any way.” And then, if that doesn’t work, in the case we’ve seen, a detainee has a bag placed over his head, he is transported with a bag placed over his head, and then he is strip searched in the presence of barking military dogs.

This is another schematic from the slideshow. I won’t go into it any detail, but it’s about the interrogation process and you can see this final slide involves a picture of everyone in the room being very happy apart from the detainee, who has a sulky face and he is in the presence of an interrogator, an analyst, and an interpreter.

With that point, I’m going to hand over to Gregg.

DR. M. GREGG BLOCHE: Thanks a lot, Jonathan. Here we go, going in the right direction here. I’m going to pick up by saying some more things about what we know, and there’s a lot we don’t know, about what these behavioral science consultation teams did. At Guantanamo, the team, which was up and running by late 2002, was usually staffed by both a psychologist and a psychiatrist as well as an aide. At Abu Ghraib, it was only intermittently staffed by even one of these professionals; either a psychiatrist or a psychologist. The first Guantanamo professional – I’m sorry, Abu Ghraib mental health professional was a psychiatrist.

Now, there is considerable resistance from traditional military intelligence personnel, steeped in the doctrine of Fort Huachuca in Arizona, who did not think that psychologists or psychiatrists had anything to contribute. The doctrinal source for this idea – the BSCT concept – was not Fort Huachuca, which is the national (propensity?) center for military intelligence doctrine. It was the John F. Kennedy School of Special Warfare at Fort Bragg, better known as one of the main centers for training of the Special Forces, including a program known as the SERE program for Survival, Evasion, Resistance and Escape, a program that puts Specials Forces trainees through experiences that constitute torture in order to ensure – in order to teach them to cope with this sort of thing, but which creates the possibility for reverse engineering of this process in order to assess which methods might be most effective at extracting of information.

Let’s walk through one doctor’s experience to get more of a sense of what this BSCT process was about. At Abu Ghraib, Major Scott Uthaw (ph), a young forensic psychiatrist, arrives in Iraq probably in November of 2003. Now, he was neither trained at Fort Bragg nor otherwise schooled in the BSCT doctrine and he was at first told he was
going to be assigned to a combat stress support unit – that’s before he goes. When he gets to Iraq, almost immediately he is attached to Abu Ghraib’s military intelligence interrogation unit and assigned to this unit’s BSCT.

Now, here is the organizational chart – part of the same slideshow Jonathan mentioned – the organizational chart for the Joint Interrogation and Debriefing Center, and we’ll focus in on it. We’ll focus in on the left side of the chart and you can see just below – on the right-hand side, center right, you see psyops, a circle with psyops and then you see the BSCT, B-S-C-T, colloquially known as “biscuit.” And there is Major Uthaw.

Now, what did Major Uthaw do and what did this BSCT do? Well, there is testimony by Colonel Thomas Pappas, who was chief of military intelligence at Abu Ghraib at the time, late ‘02 – I’m sorry, late ‘03 and early ’04; testimony given as part of General Taguba’s inquiry. Military intelligence teams prepared individual interrogation plans for detainees. These included a sleep plan and medical standards for the plans. And here is Pappas again, quote, “a physician and psychiatrist are on hand to monitor what we are doing,” unquote. And then Pappas again, quote, “the doctor and the psychiatrist look at the files to see what the interrogation plan recommends. They have the final say as to what is implemented.” Psychiatrists also went with interrogators to prison to review compliance with the management plan.

Now, some additional pieces of the BSCT puzzle from documents that have been leaked or disclosed pursuant to the Freedom of Information Act – there were one-way mirrors eventually put in at both Abu Ghraib and Guantanamo to allow observation of interrogation. And in a statement that came during the course of an Army Criminal Investigations Division inquiry, a psychologist admitted sitting in on random interrogations. And at Guantanamo, we know that another psychologist attended at least some of the interrogation sessions for the so-called “20th hijacker,” according to interrogation logs that have come to light through the efforts of Time magazine.

Now, from sources we’ve interviewed on background, we know that the Abu Ghraib interrogation site had a central hallway with three interrogation rooms on each side, and each room could be monitored from the hallway through a one-way mirror. Also, we know that psychological profiling for the purpose of developing individualized interrogation plans was part of what the BSCT teams did and there was a ferocious internal debate about the value of rapport-building interview strategies versus more aggressive approaches that were designed to facilitate reshaping of resistant detainees’ behavior.

Now, one psychological model pursued by some of the psychologists steeped in the Fort Bragg doctrine – that’s the John F. Kennedy School of Special Warfare document, and I emphasize this is only one model, there were other modes as well – one psychological model held as follows: that if you exposed detainees to uncontrollable stress in order to induce anxiety – what the behavioral physiologists call anticipatory anxiety – you then create the opportunity to reshape behavior through rewards and punishment. You induce anticipatory anxiety and then the individual is more responsive
to rewards and punishments. And this theory was based on animal studies – studies with other mammals that show greater responsiveness to behavioral rewards after anxiety is induced.

And, in fact, at Guantanamo and to a lesser extent at Abu Ghraib – to a much lesser extent – there was a complicated and nuanced reward system. There were multiple detainee status levels about which a fair amount has been reported; there were different levels of privileges and amenities, including different uniform colors, different housing situations; and the status level was specified in remarkable detail down to the number of sheets of toilet tissue issued per day.

Now, from our sources and from a leaked ICRC report on Guantanamo, it’s clear that BSCT teams and sometimes interrogators had access to medical records and information. In December, 2004, a Pentagon spokesman denied that interrogators had access to medical records, but the unclassified summary of the Church Report acknowledged that there was such access.

And more from the unclassified summary, BSCT personnel were not, quote, “permitted access to detainee medical records for purposes of developing interrogation strategies,” unquote. Interrogators, quote, “access to medical information was carefully controlled at Guantanamo” et cetera, and Assistance Secretary of Defense William Winkenwerder just a couple of months ago issued a set principles that included – that indicated that there was no, quote, “absolute confidentiality,” unquote, at Guantanamo.

Now, the implication here is that there is protection for confidentiality with some exceptions, but a document that was still in effect as of a month or two ago that became policy on 6 August, 2002, issued by Southern Command – the chief of staff of Southern Command states that in fact – and the language is in the text on the PowerPoint – states that in fact communications between detainees and military medical and other health professionals, quote, “are not confidential and are not subject to the assertion of privileges by or on behalf of detainees.” So a blanket rule of no confidentiality was in fact in effect. In other words, contrary to what Dr. Winkenwerder and others have said, these detainees did not have protections equivalent to that of American civilians in prison situations. There was no confidentiality.

Not only was there no confidentiality, but medical personnel were given reporting obligations. They were instructed that information of potential military or national security significance, quote, “shall be communicated to other United States personnel with an apparent need to know.” Whether the exchange of information with a non-medical person is initiated by the provider or by the non-medical person, in other words an obligation not just to be responsive to others’ enquiries, but to on your own as a physician determine if something – if information is of potential national security value and then to report this.

Now, another role as implied by – as suggested by the Taguba Report and Colonel Pappas’ testimony is gate-keeping with respect to, well, setting limits on aggressive
counter-resistance efforts. What do we know about that? Well, there is the famous August, 2002, Justice Department memorandum known informally as the “torture memo,” a memorandum from Assistant Attorney General Jay Bybee sought by former White House Counsel, now Attorney General Alberto Gonzales, that indicates that counter-resistance measures aren’t torture unless they bring about pain equivalent in intensity to, quote, “death, organ failure, or serious impairment of bodily functions,” unquote, or prolonged and severe mental illness. And even if these lines are crossed, it’s not torture if the interrogators act in good faith by surveying professional literature or consulting with experts. And this pushes the question of medical gate-keeping to the fore. Clearly this memo establishes physicians as gatekeepers with respect to very aggressive interrogation tactics.

There is another memo from Assistant Attorney General Bybee which has not yet been made public, but reports about this memo – again, which has not yet been leaked – reports about this memo indicate that it applies these principles to specific scenarios presented by interrogators. And (recall?) Colonel Pappas’ account of the military intelligence psychiatrist’s role at Abu Ghraib: within military medicine there has been much debate about the gate-keeping role, but military doctors have orders not to talk about this subject.

I’m going to go back to Jonathan now for some discussion of how the laws of war bear on this.

MR. MARKS: I’ll just take a couple of minutes very quickly skim –

DR. KORB: Please take about two if you could.

MR. MARKS: Okay. The first thing to acknowledge is that the administration admitted that the Geneva Conventions applied in Iraq – I don’t have time to address that case in relation to Guantanamo Bay – and the Geneva Conventions do a lot more than simply prohibit torture. They prohibit the case of POWs all sorts of violence or intimidation; they prohibit any form of coercion. In fact, they even say that detainees mustn’t be threatened, insulted, or exposed to unpleasant or disadvantageous treatment. And even unlawful combatants are provided with the same – with similar basic protections from cruel, humiliating, or degrading treatment as well as outrages on personal dignity.

And, again, there are similar provisions in the Fourth Geneva Convention in relation to civilian detainees, which I won’t repeat. And of course if these provisions are violated, then when those violations rise to the level of torture, inhuman treatment, or even willfully causing great suffering or serious injury to body or health, that is a grave breach of the Geneva Conventions and, in fact, also a war crime.

But even where the Geneva Conventions don’t apply, it’s important to recognize that international human rights law does apply, and the U.S. has signed up to two treaties, the International Convention on Civil and Political Rights, as well as the torture
convention, both of which prohibit not just torture, but cruel and inhuman degrading treatment or punishment. And indeed there is an obligation under the torture convention for the U.S. to review its interrogation policies in order to ensure that cruel and inhuman or degrading treatment doesn’t occur. There are also soft-law norms, which I won’t go through given the time constraints, but they essentially provide that detainees shouldn’t be subject to threats or methods of interrogation which impair their capacity of decision or judgment.

Now, ultimately the bottom line as far as the legal situation is concerned is that the legal barriers are likely to be crossed long before detainees’ mental or physical health is implicated particularly when those detainees are protected by the Geneva Conventions. Medical personnel, if they stand by, will be complicit in violations of the Geneva Conventions if they approve of these techniques or fail to intervene, and indeed if those abuses rise to the level of grave violations of the Geneva Convention, then they will be guilty of war crimes.

And then just to flag what in my view – what in our view is a real problem is that there is evidence there is a great deal of pressure on physicians not to intervene because we have people like Miller saying these are the worst of the worst at Guantanamo Bay, and physicians perhaps feel the pressure to save their interventions for the most egregious cases, this results in, actually, positive encouragements to interrogators who may be tempted to push the envelope, waiting for somebody to intervene in order to make them stop.

And I think that’s all I have time for on the legal front. Gregg, do you want to –

DR. BLOCHE: In 30 seconds, and then we can come back to it during our Q&A, the bottom line with respect to international medical ethics norms is that there is a prohibition on doing things that are not in an individual’s therapeutic interest, a prohibition in the World Medical Association’s regulations in times of armed conflict, but in other international norms that have the status of at least being evidence of customary international law, for instance the UN Principles of Medical Ethics, there is not a clear prohibition on doing clinical evaluations that support interrogation so long as the interrogation and counter-resistance practices fall short of torture or cruel and inhuman treatment. And there is an open ethical debate about what should and should not be prohibited and in brief just three ethical stories one could tell.

DR. KORB: Okay, let me – because you’ll have a chance to come back after the other people talk, but I want to thank you for really laying out the situation and some of the dilemmas and cross pressures. And now I’m going to ask Reuel, who has had to deal with these in real life type of situations to comment on what you’ve heard or anything else you’ll like to say on the subject.

MR. GERECHT: Thank you. I think I’m going to start off by been a little descriptive as opposed to prescriptive. I’d just say this – I mean, when I was going through agency survival and interrogation training in which the officers were starved,
denied water, frozen nearly to death, had head-splitting noise put into your eardrums hour on hour, day after day, denied sleep and otherwise abused – and which, by the way I didn’t care for at all – you know, we also had doctors in attendance. Now, I never saw one. I mean, I find out later that I remember quite well that you lose track time in these circumstances, which of course is part of the idea.

I do remember there was a gentleman that was in a cell next to me who was not taking freezing to death very well. I couldn’t see him, of course, because I was hooded with – the hood was doused with oil, so you were always on the point of retching so you couldn’t really – your senses were somewhat discombobulated, but I do remember the gentleman was not doing too well and all of sudden I heard this slurping sound in his cell and I discovered later that he in fact had been given something to drink. In fact, I discovered later that a physician had observed him and decided to give him orange juice. At the time, that annoyed me and irritated me a great, great deal because I made little whimpering sounds and I wanted to have orange juice too.

But the point of that is just that there are physicians in attendance in these things, and I spoke to officers who are going through the training who had previously served in Delta, Special Forces, and the various SEAL teams and they had similar circumstances, though their training was vastly more brutal than ours and they also had physicians in attendance, though I had the distinct impression the physicians would rarely come and see them. It really had to be life-threatening before they would come.

Now, I thought that was a good thing. I mean, I think physicians in attendance in those types of circumstances – there is nothing wrong with them. I certainly don’t see them violating any oath. I’d be surprised if they were engaged in any sort of medical research on us beforehand. They may have been, but I find that pretty worthless. I mean, I think they could review my medical file and would determine that I do not like being frozen, starved, denied sleep, and otherwise abused.

In fact, I have to say that when I hear the description always of what the military and the agency – the agency is a slightly different case – have gotten up to it, it always just rings in my ear how unprofessional it is. I mean, it is preposterous in my mind having done a lot of briefings that you would ever call in psychological or medical health to help you do it. I mean, the notion – I mean, the United States government has very, very few individuals who are qualified to deal with what you might call Middle Eastern cultural settings and the notion that you’re going to bring in some psychologist to aid you in that in any productive way I find odd. I would like to see, actually, the test results from that to see if in fact the U.S. government has ever actually gotten that much out of having professional medical assistance in attendance.

Now, I think you sort of have to backtrack it to – some of the discussion here to a basic moral question and that has nothing to do – I mean, I think on the strictly medial issue I don’t think there is anything wrong with doctors being in attendance if they are watching some type of an interrogation, particularly if it’s a rough one. I think you would rather have them there than not to be there. Now, whether they engage in certain
types of training and assistance to make the thing more effective, I could see there one could have proper moral qualms if you were a medical professional and you might want to dissent from that. However, I think you need to get back to the larger – to some extent the larger moral question, and that is do you believe there are certain circumstances where rough – very rough – interrogations are appropriate?

I personally think there are and I believe that actually almost everybody in this room if I were to set the stage up correctly would probably – maybe not be publicly, but privately also assent to it. I mean, it’s not too difficult to imagine a situation – for example, if you have a group of Muslim Europeans in the United States who are an (al Qaeda?) cell, and they in fact do have the intention and the means to let loose a weapon of mass destruction in New York City, I suspect you would want the president of the United States and the Congress to assent to rather rough interrogation tactics to break that cell.

I guarantee you it will happen. I mean, that type of thing, that type of setting – it is beyond a shadow of doubt that if that type of scenario were to happen, and I don’t think it’s terribly improbable, the president of the United States and the Congress, the committees concerned, will give at least their private assent quite quickly to very, very rough tactics. My problem is I think we should make this public. Now, I think we should have a public debate about when we want to engage in rough interrogation tactics and live by the democratic decision. So everybody should argue about this and I actually think that if you put it to the public debate and your actually have a democratic discussion of this I think you will find – that in certain circumstances you will find a majority of opinion approving a fairly rough tactics.

But what’s more important is that you will handle the slippery slope. You will determine when you should do this and when you shouldn’t and it will not be arbitrary, and you will at a minimum bring in both the president and the Congress to have some type of decision on this. And if everybody votes – by example votes against it, then we live with it. They voted against it. And if, you know, you have a strike, and people then say behind – afterwards, ex post facto, “Oh, I wish they’d engaged in rougher interrogation techniques,” then we all live with that.

Where I would fault the Bush administration is that they have not publicly engaged this issue, and I would fault Congress too. I mean, I’m not going to name names, but I’ve spoken to congressmen who are very much in favor and they are Democrats and the Republicans who are very much in favor of very, very rough tactics, but they don’t want to publicly argue the case. I just think that’s wrong. We should publicly argue with the case and than let the best man win. I mean, let the arguments stand and let everybody decide what they want to do. And I think if you were to do this, then the other issues become less troublesome. I mean, you still may have a private medical or public medical issue, and I think that’s obviously a debate that doctors have to have amongst themselves, but I think the whole question would become a lot easier if it were more publicly engaged.
And I’ll stop right there.

DR. KORB: Thank you, very much. Okay Steve, if you are wearing both hats, being in the service, being a doctor, and if could comment on anything you’ve heard up to now, I’d appreciate it.

BRIG. GEN. STEPHEN N. XENAKIS: Well, thank you. I appreciate the privilege of being on this panel and particularly want to recognize the Center for hosting this discussion and keeping the issue of military medical ethics front and center. I do want to start with a remark recognizing Dr. Korb and it’s a special privilege to be here on this – with him this afternoon. Twenty, 25 years ago when he was the assistant secretary of defense, he led a revitalization – he and a number of senior officers and the Army generals, General Max Thurman, revitalized the Army and particularly revitalized the Army medical department at a time after Vietnam when our numbers had fallen far short and we were not comfortable nor proud with the practice that we had and the support. And during those years we were able to grow a medical department and to have careers that we could hold our heads high with dignity and know that we provided high quality care as well as some of the best medical training, we felt, in the country.

And it’s that spirit, I think, of dignity and respect that I want to speak with as we get into discussion today as a physician, as a retired general, and also as a psychiatrist about what we are focusing on with respect to the interrogation. There is a – I think a broad feeling amongst many out there, active duty and retired medical people, that there is work to be done here to clarify the guidance and the policy that the medical personnel should follow and would be recognized in their practice, both in their theater in general – in this particular operation – as well as when it comes specifically to interrogation.

And what we as – the medical issues, I believe, are separate from those that we’ve talked about broadly when it comes to interrogation, in that they cover a whole host of activities from front-line care to specialty care, triage, emergency surgery, in fixed facilities as well as interrogation. There is a glimpse of that when one looks at the report that following the functional assessment team by General Martinez-Lopez, who recently retired. He is a family physician, very respected colleague, and who had put out this very exhaustive report and I think his team did a commendable effort in looking into what the events were within the course of this operation.

There are several important findings to look at. One is it appears that the run-up to the occupation period – I’ll call this the occupation we’re in now – the training, the guidance, the preparation, the supplies, as well as the staffing fall far short of what we had been used to in previous operations, fall far short of what we had used in the Gulf War, and certainly the kind of training and preparation that we did in the 1980s as part of the Cold War. That’s important because without that kind of support and without this clear guidance for what one does when one confronts scenarios of large volumes of detainees who had recently been apprehended, how they will be triaged, how they will be held, how will they be interrogated in the first part. The Army has worked on a principle of very detailed exhaustive training for all its people, and that was missing here. Despite
that, there seems to be, as you read through the report, a very good effort – in fact, a very commendable effort made by everyone.

Secondly, there was in – as we’ve articulated here in the report, a decision by the Surgeon General Kevin Kiley for the army and I think endorsed by Dr. Winkenwerder that, quote, “the same standards of care will not apply to detainees as to others in the theater.” That’s a very important statement in principle when it comes to following what we as medics do. By and large, medical personnel – those physicians and nurses – really follow the kind of the spirit of what we have been trained to do and what we’ve been asked to do in our various roles. It is the ethos of our military medical training to provide the same high quality care to anyone and everyone who deserves it. We, in fact, do not necessarily in our day-to-day business particularly slice and dice the rules and the regulations. That’s not to fault us, and that’s to say that a clear guidance and support of what we do was needed here and continues to be needed in to the future.

I think what Mr. Gerecht has articulated when it comes to the slippery slope is a very important principle because what we need in the future here from the medical people is the clearest guidance possible and a public debate about what that guidance will be. The medical people in their specialty who are – who are distinguished from the interrogators, and we distinguish from the combat people and are recognized to have a separate role, need very clear rules and regulations about what they do, as well as stated expectations. There cannot be a slippery slope. And, in fact, I think that the medical people, when you read the report, recognize that they don’t want that either. They want the clearest guidance and they want to know that what they are doing is right and that whoever looks at it will recognize and acknowledge that that they have made their best effort, and that is the next step.

We are not here to particularly target anyone or, I think, try and investigate and to do some fault finding, but to proceed further with this discussion and others, and I would like to see the endorsement of the AMA and the APA – the professional organizations – come out and help us define clearly what we all, as medical personnel, wish to have as support in that kind of theater and that kind of operation.

I also want to remark about what our contribution could be as a psychiatrist. I’m a psychiatrist, board certified in adult and child and adolescent, and I think that, again, the remark is correct: we are not trained nor are we appropriate to advice on interrogation. We should not be a part of that.

To do that really contradicts everything that we have been bred to do and I think most psychiatrists would agree to that. I think that also that the surgeon general, in saying that he will not concur with General Martinez-Lopez’ recommendation about the role of psychiatrists and psychologists with the BSCT teams is wrong in saying that. They should not be involved. Interrogators are a separate batch: trained separately, they have different experiences, they may not themselves have been particularly trained or had the opportunity to think through how they were going to carry out these particular interrogations, but that is something for them to do within their domain.
So I think that is important that the medical folks – and I would conclude with that – come across very clearly about what we are willing to do, what we are expected to do, and I would hope that we’ll get some public statements by the professional associations so that we can all go forth with confidence and that the medical departments can continue to function with that kind of self-respect that we’ve all been – we’ve been used to and appreciated.

Thank you.

DR. KORB: Thank you, Steve.

I would like to spend a few minutes have the panelists comment on some of the remarks they have heard from the other panelists before we go out and I would like to ask Jonathan and Gregg if they have any comments on what they have heard from the two commentators, and in particular Reuel’s point about let’s have a debate about the, quote, “rough stuff” and whether they – and Steve’s comment about whether the professional associations should weigh in or whether in fact there already is enough guidance.

DR. BLOCHE: I find myself in agreement with almost all of what Reuel had to say, as well what Steve had to say, especially the need for a public debate about the possibilities and limits of the rough stuff and of other methods that are on the horizon: use of neuro-imaging, for instance, is probably the next wave of interrogation. A public debate is crucial.

I do want to take issue with one thing. The question of the ethics of physician involvement is not just a professional ethics question, that needs to be part of the public debate as well. It’s not something for a professional to decide on their own. In the real world, professionals are asked by non-professionals, whether it’s commanding officers in the military, whether it’s the legal system domestically in the context of forensic and prison psychiatry, whether its insurers in the context, say, of managed care, professionals are asked to perform a whole wide range of non-therapeutic functions. And the challenge is, how do we reconcile the Hippocratic ideal of undivided loyalty to patients with this pervasive reality that physicians serve not just the military mission but all sort of other social purposes?

And there is one line of argument that needs – I want to argue be decisively rejected, and that’s the argument – the line of argument that the Pentagon civilian leadership over and contrary to the views of most medical military personnel, I think, including many in leadership roles – the line of argument that the Pentagon civilian leadership has offered up and that is that when physicians and other health professionals serve in the – as part of the interrogation mission or in other non-therapeutic roles, they are not acting as physicians, they are not acting as health professionals, and therefore medical ethics don’t apply. This is a deeply disturbing argument with little or no
precedent elsewhere. A few forensic psychiatrists began to propose this in the early ‘90s or late ‘80s, but that was roundly rejected within psychiatry.

And it is essential that not just professional associations, but the American people and the Congress make it clear that this notion that medical ethics don’t apply is unacceptable. It’s a notion that’s contrary to a whole bevvy of international law norms and international ethics norms that make it clear that physicians acting on behalf of national security remain physicians and are bound by medical ethics.

DR. KORB: Do you think Steve’s point that they have to come out and say it or have they – has it not already been said. In other words, Steve has said he would like the professional associations to say it; do they really have to say it or do doctors already know it?

DR. BLOCHE: I think they have to say it in a way that applies specifically to this. The AMA has been quite reluctant, to be blunt. We know that the AMA ethics staff prepared a letter to be from the president of the AMA in response to our first New England Journal of Medicine article and we know that by the time it came out to the New England Journal as a letter it had been much watered down to the point that it said little more than the – like Madeline in the children’s story, we should smile at the good and frown at the bad without saying what the bad and good are.

And the American Psychological Association, I think, has, well, done the AMA one better by coming out with a preliminary statement of ethics principles that permit the use of information from medical records for interrogation purposes and that do not accept the notion that international law, including international human rights law, should set limits on what either interrogators do or what psychologists do in support of interrogation. So there is a much work to be done – I agree with Steve; much work to be done by professional associations.

DR. KORB: Okay, Jonathan, let me – you can comment, make any comments you would like, but I would like you also to address the question Reuel made. Let’s say we have this referendum in the United States or a vote that allows rough stuff; putting on your barrister hat, does not that violate any of the international law – the customary international law?

MR. MARKS: Well, Larry, you preempted the point that I was very eager to make, which is that we have to bear in mind our international legal obligations when we have this discussion. If we are truly prepared to embark upon a path in which we endorse the so-called rough stuff, we have to recognize that rough stuff is cruel, inhuman, and degrading in many cases, even if it doesn’t rise to the level of torture and that our obligations are not to conduct interrogations which are cruel, inhuman, or degrading.

Now, the current attorney general takes the view that his interpretation of the torture convention is that it is all right if we do these things as long as we do them outside the United States. I think that is a very problematic and unpalatable interpretation.
my view absolutely is that we have to remember our international legal obligations and we have to think about the costs of rejecting those obligations. What will it mean for our moral standing? What will it mean in terms of setting an example? What will it mean for the U.S.’s ability to negotiate and put pressure on other nations to comply with these very same norms?

DR. KORB: Okay, any other comments you want to make? That was your –

MR. MARKS: One sort of aside I would make, and perhaps Gregg and I aren’t necessarily one on this issue, but I have a personal problem with this sort of ticking-time-bomb scenario, which is often used to justify these techniques. And that is that, of course, in the cases we were talking about – in the case of detainees in Abu Ghraib, the idea that they would have intelligence that fell within the sort of ticking-time-bomb scenario is incredibly unpersuasive. I mean, if the rationale for saving large numbers of civilian lives were good enough to justify this treatment, (that is to?) say, it doesn’t apply in Iraq, then of course it would have been very possible for the Nazis to torture British pilots they captured because we were – both sides were bombing cites, which was a violation of international law, so I would actually say that those arguments about saving civilian lives apply – would have applied in World War II.

But more importantly just let me say this: the ticking-time-bomb scenario, which as I say, it doesn’t even apply in Abu Ghraib, for example, rests on what I call sort of a omniscient narrator paradox or even fallacy, and that is it that the narrator knows – the one who tells you the story – when Reuel said, “I will set it out for you,” what he is going to set out for you is the following: we know that these detainee is a terrorist, we know that this detainee has further information, we know that if we had this information we could prevent a further attack, and we also know – fourthly – that we can’t get this information in any other way, including by rapport-building. But of course, your omniscient narrator knows all these things. What’s the one thing he doesn’t know? Precisely what that piece of information is.

And I think that very much our instincts in these are framed by filmed and television programs like “24” which set us up and seduce us into thinking that we are in true ticking-time-bomb situations and my concern is that this essentially philosopher’s hypothesis is going to be used to justify aggressive techniques in many more case.

DR. KORB: Reuel, if you would – want to comment you want to make in terms of what you heard, but if you could address two other things and one is the Warner-McCain-Graham legislation that seeks to standardize the procedures with the Army manual, and the other issue was raised by the military lawyers when the Gonzales memo came out about they’re concerned about Americans being treated with this rough stuff.

MR. GERECHT: Yeah. I mean, I was there. I am not presupposing anything. I think the reason you want to have a public debate is for precisely the reason that you don’t know. I think the scenario just premising that you have a group in the United States that has a weapon of mass destruction you are trying to find is not unreasonable, and the
rest of it is up in the air. And that’s why, in fact, you want to have a public debate on this issue.

And I just – I will dissent on this issue. I mean, torture has being around for a long time. Rough physical tactics have been around for a long time and I just suggest to you one of the reasons it’s been around for millennia is not because – just because of the human desire – sadistic human desire and the notion of justice through pain and salvation. It’s also been around because physical pain has a way of working.

Mental intimidation works; I have seen it. Mental intimidation works, and the notion that suddenly when you move over to the physical domain it doesn’t work I just find odd and I don’t think it’s historically justified, but I would just suggest that all the other people that you – let’s say all the other Westerners who have signed whatever torture agreements – if they have a similar situation, I will guarantee you the British, the French, the Italians will engage in very rough tactics if they believe that, in fact, they have got someone in a major city with a weapon of mass destruction. And what I want is just to get it out in the open, talk about it, have the debate. And if the public debate is that – and you decide that, in fact, you don’t want to do it, you don’t want to stomach it, that it is just unacceptable, then have that debate and do it.

I suspect that your elected representatives, if this scenario were to occur, will still violate that law because and in that situation, in extremis, they will engage in those rough tactics because they do believe that there is some elemental chance those rough tactics will prevent an Armageddon scenario, but at least we should debate it. And that’s what I find objectionable is that we are not doing so and, I mean, I think that’s what the democratic process is all about. I mean, democracy is supposed to handle life and death situations. I mean, that’s why capital punishment and many other issues ought to be, and is, left up to those – to democratic fora where we fight these things out, and I think we should.

I have no objection on whatsoever to standardizing military procedure. I mean, I think it’s a good idea. I am a bit confused, actually, why the – I mean, I would agree completely I think, most of the – I think there ought to be a fairly substantial review of the individuals that we have got in Guantanamo and Abu Ghraib just to ensure that the intelligence – there isn’t – there aren’t many gaps in our intelligence information. There always are, and that is not necessarily a severe criticism of the intelligence profession. I mean, I am the first one to say that I do not think we have that many people who are really capable of handling these interrogations in Arabic well.

DR. BLOCHE: Well, here is a paradox. If we retain – if we get rid of the prohibition on torture in ticking-bomb scenarios, then you have exactly the kind of slippery slope situation that Jonathan is talking about.

MR. GERECHT: Well, no. I want you to – I want to have – I want to have the discussion about the slippery slope.
DR. BLOCHE: – but if we retain the prohibition, then in those few exceptionally rare situations where the narrative of the ticking bomb is right – the kinds of situations you are talking about: the cell in the U.S. that has a nuclear bomb in Baltimore, that kind of thing, then – you know what? Yeah, I think officials will do it anyway, but they will do it in a way that’s acutely sensitive to the limitations and to their own professional and legal vulnerability if they go beyond that. So retaining the prohibition may well allow violation of the prohibition in the dark corner when it’s necessary to save 100,000 lives, but it will do something to prevent us slide down a slope.

MR. GERECHT: Well, I mean, I – there is always something to be said for, you know, hypocrisy is the vice that – you know, the homage that vice pays to virtue. However, I am a little uncomfortable with asking American citizens to engage in torture. I think – or rough tactics. We can debate which is torture and which is not. But I think these individuals that we ask to do this to protect us should be given – should be doing it, knowing that they do it with democratic approval. I don’t think they should do it on the sly when the president winks. I think these individuals should carry with them the force of law and the moral force of democratic decision behind them and that’s why I think the notion of having this discussion beforehand will help clarify this.

DR. BLOCHE: Then how do you set limits –

(Cross talk.)

DR. KORB: Okay, let me let Steve get in. We are going to –

MR. GERECHT: You set them democratically, as we set limits on a lot of different things.

DR. KORB: Okay. We are going to get – we will get back to all this, and you will all get five minutes to sum up, too, but let me ask Steve: what would you like to see as somebody with a foot in the military world and in your medical profession? What type of standards would you like to see set down?

BRIG. GEN. XENAKIS: I think they have to be absolute. I think, one, that I think there is a slippery slope that needs to be addressed when it comes to the – what would – the redefinition by health affairs of the traditional doctor’s role or physician role, that we – which in fact encompasses all of our professional practice to strictly the doctor patient relationship. I think that needs to be definitely focused in on and I do think that it then leads us down a path where physicians and other medical personnel couldn’t participate and would be expected to participate in these kinds of interrogation practices. And then there needs to be a firewall; that medical people irrespective of what might be the advisability or the legality of these interrogation practices, medical people are not a part of them.
DR. KORB: Okay, what I would like to do now, I want to turn it over to the audience. I would first like to see if there are any questions from the media since if they have any questions – yes, sir, if you would wait for the microphone and identify yourself we would appreciate it.

Q: Irv Chapman from Bloomberg Radio. Mr. Gerecht, you suggested that the use of psychologists in these circumstances is unprofessional. From what we all now know about the tactics used in Abu Ghraib and Guantanamo writ large, how professional were they overall? How effective? Did they learn anything because the continued insurgency – the growing insurgency seems to belie that they learned anything, anywhere, anyhow. And finally, how do you define “rough tactics” that are effective?

MR. GERECHT: I would have to say that much of what we have seen seems to be pretty unprofessional. That’s not terribly surprising. The United States hasn’t been in the business – or very few individuals who work for the government have been in a position to do extensive interrogation and debriefing on anyone, let alone a particular slice of young, Muslim, male, Middle Eastern populations, so that one would have a substantial learning curve is not surprising. Now, with that said, I – certainly what we have heard and many of the tactics that you have heard, and certainly in Abu Ghraib, don’t seem terribly professional.

On the efficacy of them, that’s a very good question. I mean, I don’t know. I mean, the problem is the U.S. government just reflexively classifies just about everything: you stub your toe, you classify it. In the agency, I mean, you just (need?) classification immediately as soon as you turn the computer on, and that’s quite literal. I mean, again, you have to like play with the buttons to get it unclassified. So, I mean, it becomes very difficult to get a proper assessment of whether, in fact, these interrogations with those methods are effective. I mean, that’s why I think you should start small and get bigger. It would be very good if the intel committees on Congress were to establish some type of review practice to see if, in fact, one, the intelligence agencies are checking themselves; to see if they are, in fact, engaging in quality control; and to get a very good idea if – when these methods are used what has been the result, and then be as public about it as possible so we all have some standard of measure and we are not dependent upon talking to former colleagues who are still in the business.

DR. KORB: Okay, anybody else want to comment on that? Okay, next question?

Q: I am not actually from the media. If there are still media representatives –

DR. KORB: All right. Let’s finish the media because they have to go to work. So any other media questions before we – yeah? Otto?

Q: Otto Kreisher, Copley News Service. I am going to go – how far the medical privacy thing goes. My understanding is that doctors and psychiatrists have an obligation to reveal information if a patient is self destructive or has shown homicidal tendency to somehow – that they are supposed to reveal that kind of information. You take it to a war
situation, you know, aren’t you then – doesn’t that obligation then extend to the idea that if you can obtain information that these people are a harm or a danger to the society that you have to reveal that?

DR. BLOCHE: It’s absolutely right that under prevailing ethics and law if a physician learns that a patient is putting somebody identifiable, immediate risk – an identifiable individual is in immediate risk due to a patient’s plans, then that physician has an ethical and legal obligation in the U.S. and elsewhere to report that, but it is a very dangerous move to extend that logic – to bend that logic out of shape by saying that that logic justifies revealing clinical information, revealing health vulnerabilities to behavioral scientists on BSCT teams for the purpose of crafting interrogation tactics that might have a better chance of obtaining information. That is a huge leap. It would be better if this limited exception to confidentiality in the civilian realm and in the criminal justice realm remains just as limited in the military and national security realm.

We, like Dr. Winkenwerder, don’t believe that there is an absolute norm of confidentiality and unfortunately some of the international instruments fail to accommodate the reality of a need for exceptions to confidentiality, but there is a big difference between saying there is no absolute confidentiality and saying as this August, 2002, policy that Southern Command said, that there is absolutely no confidentiality. That’s a huge problem.

DR. KORB: Steve, you want to comment on that one?

BRIG. GEN. XENAKIS: Well, there are – I think it’s – the various roles that we as military physicians have, one is the BSCT role, which is not a traditional role and one to which most psychiatrists and psychologists disagree with, is a consulting role and so that in terms of reviewing information and then providing that to someone who asks for it in sort of the strict limitations of that consulting role have their own set of rules and they are not well laid out now, particularly in this kind of operation, and that needs some further elaboration.

Secondly is the issue of confidentiality, which is different in what information we get in our – in as clinicians in treating a patient and that we learned something in the course of that treatment and this is the old Tarasoff law that this particular patient has an identified and a clear intent to hurt or kill an identified victim or to kill themselves. Under those rules, we are obligated to report that action and then safeguard the life of particularly the patient as well as the potential victim. All that is laid out; some of that is laid out within our current regulations in Army medicine, some of it still needs to be laid out, I think, of how they will apply in detainee operations and specifically how they will apply in interrogations.

There is in effect, though, when asked for, and a – there is a process for violating, I will say, or breaching confidentiality currently within Army medicine and military medicine, and that is an authority – someone in command, someone who asks for information – goes through a fairly exhaustive procedure stating what clinical
information they want and why they want to use it and going through the legal authorities to have that disclosed. Those procedures do not seem to have been practiced in this operation either, so that I think much about we are talking about is just following what are the customary rules and regulations.


Q: I assume given your background –

DR. KORB: Okay, identify yourself. I know who you are, Joe, but the audience doesn’t.

Q: Joe Galloway, Knight Ridder. I assume given your background that you had witnessed and perhaps participated in interrogations of various sorts, as have I, and have you found that using extreme tactics is very effective and produces good product or not?

MR. GERECHT: I think it’s always ideal if you can stay away from any type of physical intimidation. If you can get an individual to talk to you either through some form of seduction or mental coercion, that is always preferable. All I would say to you is the notion that physical intimidation cannot have a loosening of the lips and under the proper hands and circumstances that it can, I think, produce results. I am just am very puzzled and it seem to be a lot of commentary that was out there right before the presidential election in the United States that all forms of physical intimidation are counterproductive. I just – historically I have questions about that. I think that’s a bit dubious, but I would certainly agree that if you can keep any type of physical coercion from an interrogation room, it is far, far, far better.

DR. KORB: Last media –

MR. MARKS: Can I just –

DR. KORB: Okay, go ahead. Quickly.

MR. MARKS: It’s worth noting that the chief psychologist of the Navy Criminal Investigation Service has gone in writing to say that he believes that the more aggressive interrogation techniques are of dubious efficacy even against al Qaeda detainees even in a ticking-time-bomb scenario. And of course the choice is not should we use aggressive techniques or sit back and let the ticking bomb, if there is one, explode; it’s should we use aggressive techniques or should we work on developing and building the rapport further.

DR. KORB: Okay, last media question?

Q: Al Millikan, Washington Independent Writers. What are guidelines for religious belief being used or denied in interrogation? Does an interrogator have any
obligation to acknowledge that a terrorist is a Muslim just because they claim they are? Does one have a right or even a duty to tell a terrorist they are not a real Muslim and so treat him as a pagan or an infidel instead, even if they may sincerely believe they are a devout Muslim headed straight to paradise?

DR. KORB: Any comments?

MR. MARKS: Well, under both the laws of war and under international human rights law, if somebody claims to be a Muslim then their rights as a Muslim should be respected, which means for example that they have to be given halal food, et cetera, and that is the basic principle. I mean, you may think that they are not behaving in accordance with the law of Islam, but that does not enable you to feed them something other than halal for example.

DR. KORB: Okay, the floor is now open. The gentleman who I thought was with the media here.

Q: Thank you very much. My name is John Benjamin. I am a political counselor at the British embassy here in Washington. Prior to that, I was head of the Human Rights Department in the British Foreign Office, which is the U.K. equivalent of the State Department. Incidentally, in that capacity I worked very closely with Matrix Chambers, of which Jonathan Marks is a member, and at least in the case of his barrister colleagues I can confirm they do an awful lot more than wearing wigs, though they do that with great style.

A comment and a couple of questions to Reuel if I may. Firstly, I feel honor bound to contest somewhat your assertion that the British police would necessarily use rough tactics of the sort you describe and I think it is important to base assertions like that on actual evidence and acknowledge that when incidents occur there are criminal and independent investigatory techniques which are deployed to question and, if necessary, prosecute that sort of behavior.

I would also like to ask you a little bit more about how one might square rough tactics with both domestic and international legal obligations because if one flouts the law rather than changing the law, then one could argue there is less of a moral basis on which to take issue with others who also disregard the law and also in the case of rough physical tactics, could you say a little bit more about a claim, which I think Jonathan has already alluded to, that the most likely outcome of very rough interrogation techniques is in fact that the person being interrogated will just tell the interrogator what they want to hear rather than revealing useful information.

And finally to Gregg and Jonathan, I’d appreciate to hear whether you are in favor of legal or professional disciplinary action against medical practitioners involved in some of the issues which you have outlined today.

Thank you.
DR. KORB: Okay, that’s quite a plateful. Reuel?

MR. GERECHT: Let’s see if I can remember it all.

DR. KORB: The first thing is any evidence about the British engaging in these tactics?

MR. GERECHT: Yeah, I just – to repeat, I think the British have in the past engaged in certain rough tactics. The British history is not without example of fairly rough and vigorous behavior and that in certain circumstances that British spirit, I think, would quickly show itself, but I will defer to you if you believe that that has been wiped away –

DR. KORB: Since the empire ended?

MR. GERECHT: Yeah, I mean, I think certainly since – well, has the empire completely ended? But if you think the Brits are completely advocates of soft power now on these things, I will defer to you, but I don’t.

On legal obligations, I mean, that’s – listen, I am an American. I defer to the Congress and the president of the United States on these matters, and if the Supreme Court is pertinent to that decision they are the law of the land. So if through a democratic debate we decide that under all circumstances rough tactics are impermissible, then that’s where we should go. However, they decide and if they wish to in other people’s opinions abrogate some international treaty, then that’s for them to decide and that’s the way the democratic system works. I do not give adherence to international law over that which is determined here in Washington, DC.

And what was the question of rough – there was some question about rough tactics?

DR. KORB: Well, he wanted to know if you get – if you happened to get any information about these rough tactics?

MR. GERECHT: Yeah, I mean, again, I think that for those people to believe that you do not become more loquacious when physical pain comes your way, it’s just not true. Now, it is absolutely true that people will often say anything. Well, that’s where – I mean, historically if you look at torture, that’s where it comes into play of whether individuals can sift through this information.

I would just suggest to you that when you’re under enormous pain or duress, lies just don’t stick as well. Truth sticks. You remember the truth. It’s implanted in the brain and that for the vast majority of people, fibs just sort of roll off, but they don’t have a consistency.
That’s what normal debriefings and interrogations – if you take away physical pain, you’re just using mental seduction, mental intimidation, that’s how you actually get to the truth, is you bring over and over and over again different sets of questions so you bring down the cross hairs. And guess what? People tend to remember the truth. They cannot consistently remember lies; at least most people can’t. So if you do that long enough, through nonphysical debriefings and interrogations, you actually start to get a pattern that fits the truth and you can start to play with it, and you get there.

Again, all I suggest is that same process can also work on the physical intimidation side and that’s, I think, one of the reasons why it’s hung around human history so long, all withstanding man’s enormous sadistic impulses.

DR. KORB: Steve? Let’s hear – this is an important issue, so we’ll go right down the panel there. Not on what the British have done, but whether you get information.

BRIG. GEN. XENAKIS: Well, I mean, I cannot comment on the efficacy or the legality of rough tactics. What I want to – what I’m concerned about is where do medical people participate in that or not? And because there are conceivably several roles that need to be decided on or their participation, and one has to do with the implied role that as this kind of interrogation is occurring, that there are medical people observing it and more or less sanctioning if – is it rough or not rough or how harmful it is or not harmful, and how much pain one can inflict? I don’t see that compatible with what we do as physicians and nurses and medical people. I don’t see that that squares away with what everything else that we do. And I think that there needs to be guidance from DOD that says that we will not do that, irrespective of what the CIA and the special ops folks want to do.

Secondly, is what happens when someone’s in fact presents in a – as a casualty. They’ve been stressed too much or they’ve – you know, a wound has been inflicted or they have a fracture, and now they come to the clinic and they’re going to get treated. They get treated, again, by a standard of care that everyone else in the theater is treated according to. But what is the report obligation of the medical personnel at that time? Because the law at this point says we report it. And to whom do we report it? And are we there for protected for carrying that out? I believe we should.

When it gets to the level of the secretary of defense or the president, based on what this what debate holds, that’s another issue. Those people have – however the United States – the people of this nation decide if we do it or don’t do it, that would be – that comes out of the public debate, but as medical people our obligation is to report it and to follow all those principles.

MR. MARKS: Yeah, I’d like to –

DR. KORB: Quickly, please, so we –
MR. MARKS: Okay, I'll endorse that. But just to go onto ask the question that you put to us about detecting deception. There’s an interesting little – a collection of pieces in New Scientist – the most recent one – about this very issue, and the bottom line is it’s actually currently incredibly difficult to tell whether or not people are telling the truth, and so it is true: it’s problematic that people may tell you what you want. Generally we have about a 50 percent hit rate: 50 percent of the time you can work out whether people are telling the truth, and 50 percent of the time you get it wrong.

Now, there are – people who are working on technologies to try and improve this through the current techniques of analyzing the narrative or looking for facial tics and other expressions. It has proved incredibly unreliable. So what I would say is that, yes, at the moment, it’s incredibly difficult to filter out the truth from the lies and the new technology that people are talking about – using functional MRIs, for example – is at a very early stage. And I have spoken to people who are – and we have spoken to people who are very skeptical about it, but of course one can’t predict how that will develop.

MR. GERECHT: I mean, I would just make a quick comment there. I mean, I think that’s why the Americans have often – particularly the agency, but other branches of the government, have put so much emphasis on lie detectors. It’s because they’re trying to get rid of that very human element of the unknown. And Americans just love science; I mean, they just eat it up. So if you can have some sort of standardized test that lets you know truth from fiction, the Americans will go for it every time. But anyone who’s been in the business knows that, really, lie detectors do have their value, but they really – they’re sort of a polite form of torture. But they really work best on people who feel guilty about things, which a lot of Americans do.

DR. KORB: Okay.

DR. BLOCHE: There’s an old criminal defense lawyer’s expression: the best thing about the truth is that it makes it easier to be consistent. We’re probably never going to have an empirical answer to the question of whether rough tactics work. For one thing, doing the studies themselves would pose all sorts of ethical issues. I just want to add on this that part of the calculus for these rough tactics needs to be that there is a market for exposure in America, and we’re unlikely to be able, over the long term at least, to keep the rough tactics secret. And once they’re out in the open we need to think about the impact of the perception that Americans in their official capacity are violating the norms of the civilized world. And what that perception is going to do, both in terms of getting other countries to ally with our foreign policy objectives and discouraging versus encouraging 10 more terrorists to come forward for every one that we catch with the rough tactics.

DR. KORB: Okay. Back there. Okay, we’re getting close to the end. If you would ask your question, the question there, and – okay, two over here and then I’ll let the panelists answer as many as they can and also sum up. So please identify yourself and ask the question as quickly as you can.
Q: Great. My name is Federico Kura (ph), and I just –

DR. KORB: Where are you from, sir?

Q: I’m an unaffiliated citizen.

DR. KORB: Okay.

Q: I just – you know, regarding the comment on the possibility of having physicians witnessing interrogations perhaps to – you know, I just wonder – it – I mean, and my sense is it would all depend on who picks the doctors because if – clearly the Bush White House, for instance, picked the inspector general for overseeing the spending of the war in Iraq and it’s a Bush Republican. He’s unlikely to post any – you know, be any kind of critic. It just seems like – it’s funny to me when Bush Republicans just basically –

DR. KORB: Okay. Yeah, let –

Q: Yeah, just very, very quick. Let me just finish.

DR. KORB: Please.

Q: When they try to derail this kind of healthy debate by getting us caught up in what technically constitutes torture – I mean, it’s – if it sounds like a duck, it’s a duck. And it just seems like a strong democracy does not engage in torture and a strong democracy is the best immunity against extremism.

DR. KORB: Okay. You made – that’s a good point. Next?

Q: Thank you. Thank you. My name is Ann Cooper, and I’m from Physicians for Human Rights and I have just a couple questions. The first was following on one that was raised earlier. The question if such credible sources who are very familiar with the military, with torture, what have you, such as Senator McCain and the JAG lawyers who recently – whose memos were recently released by Senator Graham, I believe last Monday, if they are drawing issue with the use of abusive tactics and the impact that it will eventually have on the safety of U.S. forces abroad and, moreover, on potentially recruiting in the future for the military, I would like to see what you have to say about that particularly (rule?) if possible.

And then related to that, perhaps Dr. Xenakis, the question of what – or perhaps elaborating a bit on the impact on medical recruiting that the knowledge of involvement in BSCT teams might have.

And then, finally –

DR. KORB: Okay, that’s enough. Two is too – stop.
Q: Okay. Sorry.

DR. KORB: Yes.

Q: Thank you, I appreciate this.

DR. KORB: Okay. Over here and over here.

Q: Hi, I’m Kyle Kinner from Physicians for Social Responsibility. Can I ask the panelists what, if anything, we know about the secret CIA detention facilities? What kinds of interrogation practices are common there and what participation of healthcare professionals you know about? Particularly, do they have BSCT teams?

Thank you.

DR. KORB: Okay. And we have one more hand over here. Yes. Okay, two – if you go quickly. And to the –

Q: Well, I’m Damon Moglen and I’m with the Union of Concerned Scientists. And I think that many people in this country are concerned that there’s a lot of moral relativism that’s been introduced by the war on terrorism, and I’m concerned about the idea that what we need is medical associations to explain that medical professionals should not participate in torture.

And I want to go back to the last part of this gentleman’s question back here where he said, I would like to know about prosecution and responsibility; that I think we do have a situation in which there has been torture, there has been war crimes perpetrated, and that it would seem as though physicians of various kinds – and I’m not at all making a general blanket comment, but that physicians either passively or actively have been involved in activities which I do not believe the medical community thinks is right and I don’t believe that a democracy and a legal community think are right. And I would like to have the answer to the question that was raised before: if we find that this is the case, what is the history, and what are the opportunities for prosecution and for holding people accountable for this behavior?

DR. KORB: Okay. And the last question. Yeah, okay, go.

Q: I have two questions, and they’re kind of broad. One is a general policy question for Mr. Gerecht. You mentioned that there aren’t many Americans who are capable of interrogating. They don’t know the culture; they don’t know the practice. My question to you is, one, I know that there are countries – I think Saudi Arabia – in the Middle East, which has, for anymore lack of a better term, a more detainee-friendly kind of model where they kind of attempt to work with the detainees. Do you think that America or Americans are capable of adopting this kind of more effective model for
lower-level detainees or do you think that we should work more with countries that do practice this?

And then secondly, my question is for –

DR. KORB: Okay, just one is all you get. Okay. (Laughter.) We’ll get one behind you here. We’re – I’m sorry, we’re running out of time. You can come up here.

Q: All right. My name is Steve Behnke, I’m Director of Ethics for the American Psychological Association. Gregg mentioned the taskforce report. I just wanted to make two very quick points. First, is that the taskforce stated that it is unethical for a psychologist to use information from a medical record to the detriment of an individual’s health and well-being.

The second point is that the American Psychological Association made very clear that a psychologist in any work setting is bound by the ethics code; that a psychologist – I’m looking at number – point number two here – cannot step out of the role and say, “Well, I am a behavioral consultant,” or “I am a behavioral scientist and therefore the ethics code does not apply to me,” that – the taskforce very explicitly rejected that line and said the ethics code always applies to psychologists in any work setting.

DR. BLOCHE: Okay, that – let me just quickly –

DR. KORB: Okay, well, we’re all – this is going to be the last comment. What we’re going to do now – we’re going to go – we got about five minutes left. You’ve heard about six questions having to do with torture, recruiting, professional responsibility, moral relativism, culture, and the professional associations, so if you would please just go down and comment on those or anything that you would like to say to wrap up.

DR. BLOCHE: Yeah. Just briefly in response to Steve, yes – absolutely right. Your statement did reject the notion that ethics don’t apply, that if doctors don’t act as doctors, and that was a positive thing. But as you just pointed out, it’s permissible – as I think you acknowledged – it’s permissible based on the ethics guidelines developed by this taskforce to make use of confidential information, information in medical records – to make that information available to psychologists for the purposes of advising interrogators, so long as that ethic – so long as that medical information is not used to the detriment of people’s health. That allows for a wholesale breach of confidentiality in situations in which in other – in the civilian setting confidentiality is protected. It allows interrogators, through psychologists who are consultants, to tap into medical records for the purposes of developing interrogation strategies so long as harm isn’t done.

And the other problem I mentioned before about with this (3-F?) code, and I acknowledge that this is, as you’ve said in our private conversations, a work in progress, is that it doesn’t clearly embrace international law as part of the legal firmament that psychologists ought to abide by.
DR. KORB: Okay, thank you.

Jonathan, one minute to answer any of those questions or any final comments.

MR. MARKS: Yeah. First, just on interrogation approaches. The FBI has gone on record as being very upset about the more aggressive interrogation techniques that have been used in the war on terror and itself claims not to use such techniques. And I spoke to a British colleague who is involved in some of this work, and he talked favorably about the use of Imams – the idea is that when you bring someone in, and the first thing you do with detainees is you sit them down with an Imam who explains to them that this is a complete perversion of Islam, and he’s taught – I think the Brits are looking favorably at that, and that would have possibly a very positive effect on interrogation practices.

As far as accountability is concerned, I do think we need a full enquiry as to the role of physicians. The Martinez-Lopez report was just an assessment; it wasn’t a military – it wasn’t even a military enquiry, let alone a full congressional enquiry. And then I think we’d have to see what came out following that.

And thirdly, just to endorse Steve’s comments about not putting physicians in these roles, if we really do want physicians to perform these roles, we’re going to have to train them to be in the art of interrogation medicine and interrogation psychiatry. Is that really what we want for the medical profession and is that really a price we’re prepared to pay?

DR. KORB: Okay. Steve, particularly if you get to recruiting, I think that would be interesting in terms of what this might do to physicians, psychiatrists joining the Army.

BRIG. GEN. XENAKIS: I think it could have. I think it would have a large, perhaps negative, effect, but we would have to look at it. I want to just focus in from one different perspective and that is the culture of those of us who go into military medicine, and from there to tell you why I think it’s important for there to be these kinds of statements, as the American Psychological Association has made, and have it publicly debated. And that is we have gone into military medicine because we do not feel that there is a problem with dual loyalty; that we feel that in taking the oath as officers, that to support the constitution, that to defend the nation we are abiding by the highest principles as citizens and as physicians and nurses. And it is with that sense of loyalty that we go about to perform our duty.

When put into the conflict and to put into the theater of operation – you read the accounts – it is a highly ambiguous, intense-filled situation, and it is one that these folks have never – hardly ever confronted before and are forced to make choices that they did not expect to make. And it is causing a tremendous amount of internal stress and pressure on them. And so to have the backdrop of very clear statements from
professional associations, and to have them debated and to play out in policy and
guidance is affirming for them and allows us to organize our practices in a way that
conforms to our own internal principles and ethics. And I think that’s what’s important
and that’s what should follow.

DR. KORB: Okay. Reuel, final word?

MR. GERECHT: Yeah, I think just two questions. I’ll ignore the other ones,
even though they deserve a response. On Senator McCain, I have enormous respect for
Senator McCain. He obviously has a good, if not unique, standing to comment on
interrogation and pain. I mean, I certainly would be very sympathetic to a
standardization, if not outright ban, on a whole variety of tactics that – under the auspices
of the U.S. military. I mean, if I were the military, despite whatever qualms I might have
about agency – CIA competence, I would like to get as far away as possible from the
interrogation of terrorists.

Now, others – that’s a different issue, but I mean, I think it’s – and obviously that
begins to blur a bit in certain cases of tactical consideration, say in Iraq where you have
suicide bombers and that, but I would certainly be sympathetic to any legislation that
Senator McCain would put forward on trying to ban brutal tactics by the military.

However, it would be interesting to pose the question to Senator McCain – and I
followed fairly closely what he said. I haven’t heard him say that he is opposed to rough
interrogation under all circumstances by all agencies, and it would be interesting to pose
that question to him: does he believe that’s the case? And I would weight that response.

On your question, which I think touched on rendition, I’m opposed to rendition in
all circumstances. At least I think I am. I haven’t thought of a circumstance yet where I
don’t oppose it, so – and I’m also amused by your choice of Saudi Arabia as being
detainee friendly. I think that’s – to be very polite to them. So I would oppose rendition.
I don’t think we should be in the business of it. If we’re going to do these things, we
should do them ourselves. And they corrupt American foreign policy.

DR. KORB: Well, I want to thank all of the panelists for a lively discussion. I
apologize for having to cut you off and cut off some of the questions. I did want to give
everybody as much a chance as I could. I want to thank Ken Gude, our associate director
for international rights and responsibilities for putting this together; Antoine Morris and
Alex Pryor who did all of the work to make this happen; the New England Journal of
Medicine for allowing us to reproduce the article you have in your book; and also to say
that if you would like to come back again next week at this same time and same place,
we’re going to have a panel on “New Strategies to Protect America: Terrorism and Mass
Transit after London and Madrid.” And also, Steve, thank you very much for those nice
comments about me. I certainly appreciate it.

Thank you all for coming. (Applause.)
(END)