

Perspective

Medical Ethics and the Interrogation of Guantanamo 063

Steven H. Miles, University of Minnesota Center for Bioethics

The controversy over abusive interrogations of prisoners during the war against terrorism spotlights the need for clear ethics norms requiring physicians and other clinicians to prevent the mistreatment of prisoners. Although policies and general descriptions pertaining to clinical oversight of interrogations in United States' war on terror prisons have come to light, there are few public records detailing the clinical oversight of an interrogation. A complaint by the Federal Bureau of Investigation (FBI) led to an Army investigation of an interrogation at the United States prison at Guantanamo Bay. The declassified Army investigation and the corresponding interrogation log show clinical supervision, monitoring and treatment during an interrogation that employed dogs, prolonged sleep deprivation, humiliation, restraint, hypothermia and compulsory intravenous infusions. The interrogation and the involvement of a psychologist, physician and medics violate international and medical norms for the treatment of prisoners.

Keywords: human rights, military medicine, war, medical ethics

The controversy over clinical collaboration with the interrogational abuse of prisoners during the war against terrorism has renewed interest on the ethics of military clinicians working in prisoner of war facilities. A large literature describes human rights abuses in United States' war on terror prisons and the origin and content of interrogation policies. These policies originated with senior White House, Department of Justice and Department of Defense officials, specified how to stress prisoners during interrogation and were passed down the chain of command to poorly trained and supervised Army interrogators (Fay 2004; Greenberg and Dratel 2005; Margulies 2006).

Secretary of Defense Rumsfeld's directed that "interrogations must always be planned deliberate actions that take into account a detainee's emotional and physical strengths and weaknesses [and] . . . manipulate the detainees emotions and weaknesses to gain his willing cooperation" (Rumsfeld 2003, 5). To this end, General Geoffrey Miller, commander of the detention centers at Guantanamo, created Behavioral Science Consultation Teams (BSCTs), which he defined as, "teams comprised of operational psychologists and psychiatrists [. . .] essential in developing integrated interrogation strategies and assessing interrogation intelligence production" (Miller 2003, 5). The BSCTs, "biscuits" as they were colloquially called, reported to intelligence officials who were ultimately responsible for approving interrogational plans and who determined what information was to be solicited from the prisoner (Figure 1) (Bloche and Marks 2005; Physicians for Human Rights 2005).

BSCTs in Iraq and at Guantanamo Bay were chaired by a psychiatrist or psychologist, and advised on how to exploit the prisoners' emotional and physical vulnerabilities

and how to monitor the success of the interrogation (Miles 2006). BSCT personnel suggested how to stress, coerce and offer incentives in order to secure information. These behavioral science clinicians designed a two-pronged approach to break the prisoners down. The first was an attack on the cultural self of the Islamic men. As Guantanamo's Muslim Chaplain James Yee put it, "Islam is not just a religion; it is a way of life" (Yee 2005, 110). Yee observed that Islamic identity became the most important weapon against the prisoners: prayer times were disrupted, the Koran was handled disrespectfully, and Islamic rules regarding decent interactions between men and women were violated (Yee 2005, 100–117). The second approach aimed at a prisoner's personal vulnerabilities, sometimes using information from the prisoner's medical record (Miles 2006, 55–65). Rumsfeld's policy also called for "qualified medical personnel" to be present or available during harsh interrogations (Rumsfeld 2003). Defense Department documents describe the policies and the clinical vetting and monitoring of interrogations (Miles 2006, 43–67). However, such investigations generally focus on patterns of abuse rather than on elucidating the specific roles of clinicians in individual interrogations.

Ironically, most of Guantanamo Bay prisoners either had no intelligence value or were innocent of Al-Qaeda, Taliban or insurgency activity (Denbeaux et al. 2006).

The Interrogation of Prisoner 063

Two government documents detail medical and psychological participation with the interrogation of Prisoner 063, Mohammed al-Qahtani, at Guantanamo Bay between November 23, 2002 and January 11, 2003 (Zagorin and Duffy 2005). The first is an 83-page interrogation log (ORCON 2003). The

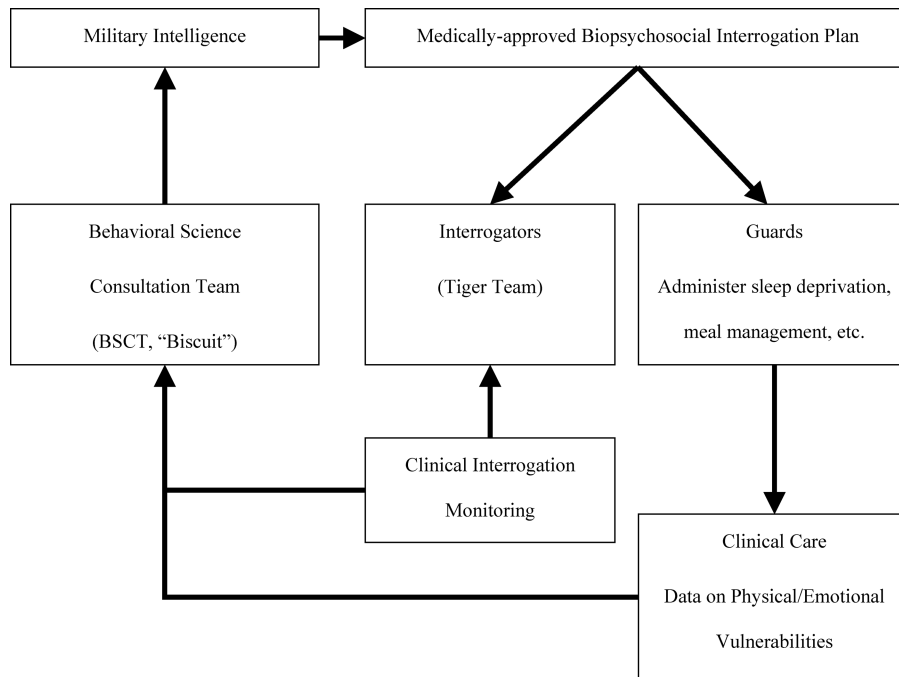


Figure 1. Medical and Behavioral Science Integration into Interrogations.

second is an Army investigation of complaints of mistreatment of prisoners at Guantanamo Bay, including Prisoner 063 (United States Army 2005, 13–21). The third and fourth are notes taken in relation to that Army investigation (CTD Fly Team 2006; GITMO Investigation 2004). The second set of these notes extensively describes medical collaboration with one or more interrogations but the record is so heavily redacted that it is not possible to determine which, if any, of this material described the interrogation of Prisoner 063 (GITMO Investigation 2004).

According to the Army investigation, the log covers a period in the middle of al-Qahtani’s interrogation that began in the summer of 2002 and continued into 2003. For eleven days, beginning November 23, al-Qahtani was interrogated for twenty hours each day by interrogators working in shifts. He was kept awake with music, yelling, loud white noise or brief opportunities to stand. He then was subjected to eighty hours of nearly continuous interrogation until what was intended to be a 24-hour “recuperation.” This recuperation was entirely occupied by a hospitalization for hypothermia that had resulted from deliberately abusive use of an air conditioner. Army investigators reported that al-Qahtani’s body temperature had been cooled to 95 to 97 degrees Fahrenheit (35 to 36.1 degrees Celsius) and that his heart rate had slowed to thirty-five beats per minute. While hospitalized, his electrolytes were corrected and an ultrasound did not find venous thrombosis as a cause for the swelling of his leg. The prisoner slept through most of the 42-hour hospitalization after which he was hooded, shackled, put on a litter and taken by ambulance to an interrogation room for twelve more days of interrogation, punctuated

by a few brief naps. He was then allowed to sleep for four hours before being interrogated for ten more days, except for naps of up to an hour. He was allowed 12 hours of sleep on January 1, but for the next eleven days, the exhausted and increasingly non-communicative prisoner was only allowed naps of one to four hours as he was interrogated. The log ends with a discharge for another “sleep period.”

Medical Treatment during Interrogation

Clinicians regularly visited the interrogation cell to assess and treat the prisoner. Medics and a female “medical representative” checked vital signs several times per day; they assessed for dehydration and suggested enemas for constipation or intravenous fluids for dehydration. The prisoner’s hands and feet became swollen as he was restrained in a chair. These extremities were inspected and wrapped by medics and a physician. One entry describes a physician checking “for abrasions from sitting in the metal chair for long periods of time. The doctor said everything was good.” Guards, medics and a physician offered palliative medications such as aspirin to treat his swollen feet.

Intravenous fluids were regularly administered over the prisoner’s objection. For example, on November 24, the prisoner refused water. A Captain-interrogator advised him that the medic “can administer IV [sic: the log’s contraction for intravenous fluids of an unspecified volume is used throughout this article] fluids once the Captain and the Doctor on duty are notified and agree to it.” Nine hours later, after taking vital signs, medical personnel administered “two bags” of intravenous fluids. Later that day, a

physician evaluated al-Qahtani in the interrogation room and told him that he could not refuse medications or intravenous fluids, and that he would not be allowed to die.

The next day, interrogators told the prisoner that he would not be allowed to pray if he would not drink water. Neither a medic nor a physician could insert a standard intravenous catheter, so a physician inserted a "temporary shunt" to allow an intravenous infusion. The restrained prisoner asked to go to the bathroom and was given a urinal instead. Thirty minutes later, he was given "three and one-half bags of IV [sic]" and he urinated twice in his pants. The next day, the physician came to the interrogation room and checked the restrained prisoner's swollen extremities and the shunt. The shunt was removed and a soldier told al-Qahtani that he could pray on the floor where he had urinated.

From December 12 to 14, al-Qahtani's weight went from 119 to 130 pounds (54 to 59 kilograms) after being given six IVs. On December 14, al-Qahtani's pulse was 42 beats per minute. A physician was consulted by phone and said that "operations" could continue since there had been no significant change. Al-Qahtani received three more IVs on the December 15 and complained of costophrenic pain. A physician came to the interrogation cell, examined him, made a presumptive diagnosis of kidney stones and instructed the prisoner to take fluids. The next day blood was drawn in the cell.

Psychological Treatment During Interrogation

In October 2002, before the time covered by the log, Army investigators found that dogs were brought to the interrogation room to growl, bark and bare their teeth at al-Qahtani. The investigators noted that a BSCT psychologist witnessed the use of the dog, Zeus, during at least one such instance, an incident deemed properly authorized to "exploit individual phobias." FBI agents, however, objected to the use of dogs and withdrew from at least one session in which dogs were used.

Major L., a psychologist who chaired the BSCT at Guantanamo, was noted to be present at the start of the interrogation log. On November 27, he suggested putting the prisoner in a swivel chair to prevent him from fixing his eyes on one spot and thereby avoiding the guards. On December 11, al-Qahtani asked to be allowed to sleep in a room other than the one in which he was being fed and interrogated. The log notes that "BSCT" advised the interrogators that the prisoner was simply trying to gain control and sympathy.

Many psychological "approaches" or "themes" were repetitively used. These included: "Failure/Worthless," "Al Qaeda Falling Apart," "Pride Down," "Ego Down," "Futility," "Guilt/Sin Theme (with Evidence/Circumstantial Evidence," etc. Al-Qahtani was shown videotapes entitled "Taliban Bodies" and "Die Terrorist Die." Some scripts aimed at his Islamic identity bore names such as "Good Muslim," "Bad Muslim," "Judgment Day," "God's Mission" and "Muslim in America." Al-Qahtani was called "unclean" and "Mo" [for Mohammed]. He was lectured on the true mean-

ing of the Koran, instruction that especially enraged him when done by female soldiers. He was not told, despite asking, that some of the interrogation took place during Ramadan, a time when Moslems have special obligations. He was not allowed to honor prayer times. The Koran was intentionally and disrespectfully placed on a television (an authorized control measure) and a guard "unintentionally" squatted over it while harshly addressing the prisoner.

Transgressions against Islamic and Arab mores for sexual modesty were employed. The prisoner was forced to wear photographs of "sexy females" and to study sets of such photographs to identify whether various pictures of bikini-clad women were of the same or a different person. He was told that his mother and sister were whores. He was forced to wear a bra, and a woman's thong was put on his head. He was dressed as a woman and compelled to dance with a male interrogator. He was told that he had homosexual tendencies and that other prisoners knew this. Although continuously monitored, interrogators repeatedly strip-searched him as a "control measure." On at least one occasion, he was forced to stand naked with women soldiers present. Female interrogators seductively touched the prisoner under the authorized use of approaches called "Invasion of Personal Space" and "Futility." On one occasion, a female interrogator straddled the prisoner as he was held down on the floor.

Other degrading techniques were logged. His head and beard were shaved to show the dominance of the interrogators. He was made to stand for the United States national anthem. His situation was compared unfavorably to that of banana rats in the camp. He was leashed (a detail omitted in the log but recorded by investigators) and made to "stay, come, and bark to elevate his social status up to a dog." He was told to bark like a happy dog at photographs of 9/11 victims and growl at pictures of terrorists. Some psychological routines referred to the 9/11 attacks. He was shown pictures of the attacks, and photographs of victims were affixed to his body. The interrogators held one exorcism (and threatened another) to purge evil Jinns that the disoriented, sleep-deprived prisoner claimed were controlling his emotions. The interrogators quizzed him on passages from a book entitled, "What makes a Terrorist and Why?," that asserted that people joined terrorist groups for a sense of belonging and that terrorists must dehumanize their victims as a way to avoid feelings of guilt at their crimes.

Discussion

Clinicians were integral to this abusive interrogation. Medics regularly assessed al-Qahtani's vital signs, hydration, skin integrity and constipation. They attended to edema that appears to have resulted from a combination of prolonged restraint, recumbency and (perhaps) nutritional insufficiency. Physicians came to the interrogation cell to assess or treat dehydration, inanition, pain, edema and potential trauma from prolonged restraint to a metal chair. A physician told interrogators over the telephone that interrogation could continue despite bradycardia. Inpatient

clinicians treated hypothermia-induced bradycardia and returned him to the interrogators. The Behavioral Science Consultation Team and its psychologist Chair oversaw the interrogation, including the use of a military dog to threaten the prisoner, and directly suggested responses to the prisoner's requests and actions.

The Army investigation, instigated by an FBI complaint rather than by clinicians, focused on whether the interrogation techniques were authorized by Defense Department policy. The investigators found that the prolonged sleep deprivation was authorized. Cooling with an air conditioner was authorized "environmental manipulation." Notwithstanding bradycardia requiring hospitalization, the investigators asserted, "There are no medical entries indicating the subject . . . ever experienced medical problems related to low body temperature" (Bashour, Gualberto and Ryan 1989). Investigators noted a second episode of bradycardia in February 2003 after the period covered by interrogation log. Army investigators found no evidence that al-Qahtani was ever physically assaulted and pointed out that medical records did not find evidence of physical assault or "medical conditions of note." They concluded that there was "no evidence that [al-Qahtani] . . . was subjected to humiliation intentionally directed at his religion." They found that the cumulative effect of this "creative, aggressive, and persistent" interrogation was "degrading and abusive" but did not constitute "torture" or "inhumane" treatment but did not define distinctions between these words. Not finding torture or inhumane treatment, the Army recommended closing the investigation.

Defense Department officials defend this interrogation as conducted according to a "very detailed plan" by "trained professionals in a controlled environment, with active supervision and oversight" (Department of Defense 2005). They allege that al-Qahtani was the twentieth hijacker who provided valuable intelligence about Al Qaeda operations and 9/11 planning, and that he identified "about 30" bin Laden bodyguards held at Guantanamo. No trials are known to have resulted from this information, however, and al-Qahtani professes to be a broken man who gave false information under pressure (Zagorin 2006).

International law squarely prohibits this kind of interrogation. The Geneva Convention relative to the Treatment of Prisoners of War states,

Persons . . . placed hors de combat by . . . detention shall in all circumstances be treated humanely, . . . To this end the following acts are and shall remain prohibited at any time and in any place whatsoever . . . (c) Outrages upon personal dignity, in particular, humiliating and degrading treatment; . . . No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind (Geneva Convention 1949).

Similarly, the United Nations' Convention Against Torture defines "torture" as "any act by which severe pain or

suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, . . . at the instigation of . . . a public official" (United Nations General Assembly 1984). Although the United States Supreme Court upheld the Geneva Convention in its Hamdan decision (*Hamdi v. Rumsfeld*, 124 S. Ct. 2633 [2004]), the recently enacted Military Commissions Act denies prisoners the right to invoke the Geneva provisions (Military Commissions Act of 2006).

Numerous ethics codes proscribe medical complicity with harsh interrogation. In response to public outcry against clinical participation in coercive interrogations at war on terror prisons, the American Medical Association and the American Psychiatric Association have endorsed more stringent codes for military clinicians who are asked to participate in interrogation (Table 1). The American Psychological Association (APA) has taken a different tack and allows psychologists to assist in military interrogations (APA 2006). Although it bars psychologists from assisting in torture or cruel, inhuman or degrading treatment, its restrictive definition of those terms follows the United States' reservations to the United Nations' Convention Against Torture (APA Council of Representatives 2006). The APA asserts that psychologists are trained to detect and prevent "behavioral drift" that can lead to unethical interrogations (Behnke 2006). This optimistic view of behavioral clinicians is contradicted by many examples of psychologists and psychiatrists who have collaborated with torture in diverse countries.

The diverse clinical societies' ethics codes should be harmonized and unequivocally grounded on the standards in international laws like the Geneva Convention. In this way, the United States medical community would express its accountability to international law and be able to call upon foreign governments and medical communities to do likewise.

In that the al-Qahtani interrogation is a case report, limited inferences can be drawn. However, it does comport with the larger literature on clinical involvement with interrogations in war on terror prisons. Al-Qahtani was an important suspect; undoubtedly, his interrogation was especially, although not uniquely, harsh. Less severe interrogations used similar techniques and also involved clinicians. The Defense Department could address concerns about interrogations and clinicians by declassifying more logs. Such logs do not contain national security data. Medical societies have not called for an independent assessment of the clinical roles during interrogations.

This interrogation illuminates the flaw in the Defense Department' policy that proposes a distinction between the ethical duties of clinicians who treat a prisoner and those who assist interrogators (Assistant Secretary of Defense 2005; Department of Defense 2006). It is untenable to propose that 063's hospital physician had a duty to treat hypothermic bradycardia and accommodate the interrogational clinician who supervised the "environmental manipulation." The physician in the interrogation cell who ordered parenteral fluids over the prisoner's objection did not

Table 1. Selected Excerpts from Medical Ethics Codes and Conventions Addressing Clinicians Roles in Interrogation.

United Nations General Assembly. Principles of Medical Ethics Relevant to the Protection of Prisoners Against Torture (1982).

It is a gross contravention of medical ethics, . . . for health personnel, particularly physicians, to [1] engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment, . . . [2] be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health, . . . [3] (a) apply their knowledge and skills in order to assist in the interrogation of prisoners . . . in a manner that may adversely affect the physical or mental health or condition of such prisoners . . . ; (b) certify, or to participate in the certification of, the fitness of prisoners . . . for any form of treatment or punishment that may adversely affect their physical or mental health . . . or to participate in any way in the infliction of any such treatment or punishment . . . , [4] participate in any procedure for restraining a prisoner . . . unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself . . . and presents no hazard to his physical or mental health.

World Medical Association. Guidelines for Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment, [Declaration of Tokyo] (1975).

The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.

The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations, including armed conflict and civil strife.

The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened.

American Psychiatric Association (2006).

No psychiatrist should participate directly in the interrogation of persons held in custody Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.

American Medical Association (2006).

Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physicians' role as healer and thereby erodes trust in both the individual physician-interrogator and in the medical profession. Physicians should not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation. Physicians may participate in developing effective interrogation strategies that are not coercive but are humane and respect the rights of individuals. When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

Royal College of Psychiatrists (2006).

The Royal College of Psychiatrists welcomes the following statements in the Surgeon General's Policy Letter Medical Support to Persons Detained by UK Forces whilst on Operations:

- a. "It is a gross contravention of medical ethics, as well as an offence under applicable international instruments and UK law for health personnel, particularly registered medical practitioners, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment."
- b. "Health personnel are only to be involved in professional relationships with prisoners or detainees for the purposes of evaluating, protecting or improving their physical and mental health."
- c. "Health personnel are not to: i. Apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect their physical or mental health; this includes certifying or stating that a detainee meets a specific mental or physical standard for interrogation. ii. Certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health, or to participate in any way in the infliction of any such treatment or punishment. iii. Question detainees about matters unless they are relevant to their medical care."

simply treat a dehydrated patient, he or she prolonged a harsh interrogation. The psychologist who oversaw the use of dogs, sleep deprivation and culturally-targeted humiliation was using clinical insights and the tools of behavioral

science to break a prisoner down rather than to establish rapport for cross cultural negotiation. Al-Qahtani had no treating psychologist. This problem is not resolved by simply invoking "dual loyalty ethics." In this situation,

dual loyalty ethics, like international law, obliges the clinicians who work in environments pressuring them to do otherwise to hold the wellbeing of their imprisoned patients as their primary obligation (International Dual Loyalty Working Group 2002). ■

REFERENCES

American Medical Association. 2006. AMA Council on Ethical and Judicial Affairs. Statement on interrogation of prisoners. July 7, 2006. Available online at <http://pn.psychiatryonline.org/cgi/content/full/41/13/4-a>. Accessed on January 30, 2006.

American Psychiatric Association. 2006. Psychiatric participation in interrogation of detainees. May 21, 2006. Available online at http://www.psych.org/edu/other_res/lib_archives/archives/200601.pdf. Accessed on January 30, 2006.

American Psychological Association. 2005. Report of Presidential Task Force on Psychological Ethics and National Security. Jul. 5 2005. Available online at <http://www.apa.org/releases/pens0705.html>. Accessed on October 30, 2006.

American Psychological Association Council of Representatives. 2006. American Psychological Association 2006 Resolution Against Torture and Other Cruel, Inhuman, and Degrading Treatment or Punishment. Aug. 9, 2006. Available online at <http://www.apa.org/convention06/notortureres.html>. Accessed on October 30, 2006.

Assistant Secretary of Defense. 2005. Medical program principles and procedures for the protection and treatment of detainees in the custody of the armed forces of the United States. Jun. 3, 2005. Available online at <http://www.phrusa.org/research/torture/pdf/dodpolicy.pdf>. Accessed on October 30, 2006.

Bashour, T. T., A. Gualberto, and C. Ryan. 1989. Atrioventricular block in accidental hypothermia—a case report. *Angiology* 40: 63-66.

Behnke, S. 2006. Ethics and interrogations: Comparing and contrasting the American Psychological, American Medical and American Psychiatric Association positions. *Monitor on Psychology* 37: 66.

Bloche, M. G., and J. H. Marks. 2005. Doctors and interrogators at Guantanamo Bay. *New England Journal of Medicine* 353: 6-8.

CTD Fly Team. 2006. Interviews [declassified June 19, 2006]. Available online at [http://www.aclu.org/torturefoia/legaldocuments/july_docs/\(M\)%20SCHMIDT-FURLOW%20DEFERRED.pdf](http://www.aclu.org/torturefoia/legaldocuments/july_docs/(M)%20SCHMIDT-FURLOW%20DEFERRED.pdf). Accessed on January 30, 2006.

Denbeaux, M., J. Denbeaux, D. Gratz, J. Gregorek, M. Darby, S. Edwards, S. Hartman, D. Mann, and H. Skinner. 2006. Report on Guantanamo detainees: A profile of 517 detainees through analysis of Department of Defense data. Feb. 8, 2006. Available online at http://www.cfr.org/publication/9838/seton_hall.html. Accessed on October 30, 2006.

Department of Defense. 2005. Guantanamo provides valuable intelligence information. News Release 592-05, June 12, 2005. Available online at <http://www.defenselink.mil/releases/2005/nr20050612-3661.html>. Accessed on October 30, 2006.

Department of Defense. 2006. Medical program support for detainee operations. June 6, 2006. Available online at http://www.dtic.mil/whs/directives/corres/pdf/231008_060606/231008p.pdf. Accessed on October 30, 2006.

Accessed on October 30, 2006.

Fay, G. R. 2004. Investigation of the Abu Ghraib Detention facility and 205th Military Intelligence Brigade. Aug. 2004. Available online at <http://www.defenselink.mil/news/Aug2004/d20040825fay.pdf>. Accessed on October 30, 2006.

Geneva Convention. 1949. Convention relative to the treatment of prisoners of war. August 12, 1949. Available online at <http://www.unhchr.ch/html/menu3/b/91.htm>. Accessed on October 30, 2006.

GITMO Investigation. 2004. AR 15-6 report. FBI allegations of Abuse. Available online at <http://action.aclu.org/torturefoia/released/061906/Schmidt.FurlowEnclosures.pdf>. Accessed January 30, 2007.

Greenberg, K. J., and J. L. Dratel (eds). 2005. *The torture papers: The road to Abu Ghraib*. New York, NY: Cambridge University Press.

International Dual Loyalty Working Group. 2002. *Dual loyalty and human rights in health professional practice: Proposed guidelines and institutional mechanisms*. Boston, MA: Physicians for Human Rights.

Margulies J. 2006. *Guantanamo and the abuse of Presidential power*. New York, NY: Simon & Schuster.

Miles, S. H. 2006. *Oath betrayed: Torture, medical complicity and the War on Terror*. New York, NY: Random House.

Military Commissions Act of 2006. *Pub. L. No. 109-366, 120 Stat. 2600 (Oct. 17, 2006)*. Available online at <http://thomas.loc.gov/cgi-bin/query/D?c109:3::/temp/~c109yhx7a::> Accessed on January 30, 2007.

Miller, G. 2003. Assessment of DOD counterterrorism interrogation and detention operations in Iraq. Sep. 9, 2003. Available online at <http://www.publicintegrity.org/docs/AbuGhraid/Abu3.pdf>. Accessed on October 30, 2006.

ORCON [Authoring agency classified by Originator Control]. 2003. Interrogation log Detainee 063. Available online at <http://www.time.com/time/nation/article/0,8599,1169322,00.html>. Accessed on October 30, 2006.

Physicians for Human Rights. 2005. Break them down: Systematic use of psychological torture by US Forces. Available online at http://www.physiciansforhumanrights.com/research/torture/pdf/psych_torture.pdf. Accessed on January 30, 2006.

Royal College of Psychiatrists. 2006. Resolution condemning psychiatric participation in the interrogation of detainees, whether in military or civilian settings. Annual Meeting 2006. Glasgow, Scotland. July 12, 2006. Available online at <http://www.rcpsych.ac.uk/pressparliament/pressreleases2006/pr825.aspx>. Accessed on January 30, 2006.

Rumsfeld, D. R. 2003. Memorandum for the Commander, US Southern Command; Counter resistance techniques in the War on Terrorism. Apr. 16, 2003. Available online at <http://www.gwu.edu/~nsarchiv/NSAEBB/NSAEBB127/03.04.16.pdf>. Accessed on October 30, 2006.

United Nations General Assembly. 1982. Principles of medical ethics relevant to the protection of prisoners against torture. Dec. 18, 1982. Available online at http://www.cioms.ch/1983.texts_of_guidelines.htm. Accessed on October 30, 2006.

United Nations General Assembly. 1984. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Dec. 10, 1984. Available online at http://www.unhchr.ch/html/menu3/b/h_cat39.htm. Accessed on January 30, 2007.

United States Army. 2005. Final report: Investigation into FBI allegations of detainee abuse at Guantanamo Bay, Cuba detention facility, Apr. 1, 2005. Available online at <http://www.dod.gov/news/Jul2005/d20050714report.pdf>. Accessed on October 30, 2006.

World Medical Association. 1975. Declaration of Tokyo: Guidelines for medical doctors concerning torture and other cruel,

inhuman or degrading treatment or punishment in relation to detention and imprisonment. Available online at <http://web.amnesty.org/pages/health-ethicswmatokyo-eng>. Accessed on October 30, 2006.

Yee, J. 2005. *For God and country*. New York, NY: Public Affairs Press.

Zagorin, A., and M. Duffy. 2005. Inside the interrogation of detainee 063. *Time* Jun. 20: 26–33.

Zagorin, A. 2006. 20th hijacker' claims that torture made him lie. *Time* (web exclusive) May 3. Available online at <http://www.time.com/time/nation/article/0,8599,1169322,00.html>. Accessed on October 30, 2006.