



## Glimpses of Guantanamo — Medical Ethics and the War on Terror

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On a rainy afternoon in mid-October 2005, a white bus climbed the brush-covered hills near Guantanamo Bay, Cuba, carrying a group of visitors to Camp Delta, the desolate spot on the island's

southern coast where the U.S. military holds more than 500 prisoners captured in the war on terror. It rolled through the detention camp's stockade-style gate and turned onto the dirt track inside the outermost of three high fences. Like others in the small group of civilian doctors, psychologists, and ethicists visiting that day, I peered through the bus's windows, eager for a glimpse of detainees. Since our arrival in the morning, we had spent more than two hours in a hospital conference room on the naval base, listening to a briefing by Major General Jay W. Hood, the camp's commander, and questioning him and other officials about the interrogation and medi-

cal care of detainees, including the force-feeding of hunger strikers. At last, I thought, we were about to see the prisoners.

The fences veiled the camp's interior from our curious eyes. Opaque green cloth was stretched across the chain link, obstructing our view of the buildings beyond. As we rolled slowly past Camps 3, 2, and 1, adjoining compounds with similar layouts, we caught an occasional glimpse of the military guards who sit in open doorways at the rear of each cell block, keeping a constant eye on the detainees within. ("There is no place in those blocks where people can disappear and not be watched by multiple eyes," Hood said —

adding, however, that guards carry no weapons: "It's the safest way to run a facility.")

For a moment, I saw a prisoner's olive-skinned face peeking out at our bus through a hole in the cloth. Then, we rounded a corner and reached Camp 4, the least restrictive of the five currently occupied prison compounds. We saw 10 or 12 prisoners standing alone or in small groups in the exercise yard. They wore white pants and shirts. Most had long, black hair; many had untrimmed beards, and a few wore white caps. One man was chinning himself on a metal crossbar supporting an awning that shaded part of the yard. From a distance, through the layers of fence, the detainees watched silently as our military escorts hustled us into the prison hospital.

We found ourselves in a long, one-story building with gray-paint-



Department of Defense Photograph of Detainee Hospital Ward at Camp Delta, Guantanamo Bay, Cuba.

ed metal walls and a spotless linoleum floor. Our guides led us down a hallway past physical therapy equipment, an x-ray room, a glass-windowed nurses' station, and a supply room full of surgical kits and medical equipment. We stopped outside the hospital's empty operating room. There we were greeted by members of the medical team led by a physician known to patients as Dr. O., a young military doctor with a buzz cut and a mustache. The camp's doctors, nurses, and prison guards hide their name tags from prisoners with masking tape, and officials asked us not to publish their names, to protect them and their families from terrorists.

The patients — nine in all, we were told — were invisible. They lay behind floor-to-ceiling curtains covering the bays of the 30-bed hospital. Guards standing before the curtains came to attention the moment I tried to edge closer. I had been told before the trip that we would probably be permitted to speak with patients, and I received various explanations for the change of heart:

officials didn't want to give hunger-striking patients a forum for media attention; they feared that a patient who had assaulted a nurse the previous night might again become disruptive or violent; they were concerned about detainees' privacy. Had I known that I would not have access to prisoners, I might have declined the invitation to visit Guantanamo, as United Nations representatives have since done.

Captain John S. Edmondson, an emergency physician and the commander of the medical group that delivers the prisoners' care, told us that eight of the patients had been admitted for involuntary tube feeding, to treat the medical consequences of their prolonged hunger strike. We were told that 25 prisoners were on hunger strike that day (a decline from 131 on the anniversary of the September 11 attacks) and that 22 were being fed by nasogastric tube — most while in their cells. Some had continued to lose weight — as much as 30 percent of their original body weight — despite these tube feedings and had been

admitted for monitoring, endocrinologic evaluation, and additional treatment. "They are all clinically stable" with albumin levels over 4 g per deciliter, said Edmondson, a dark-haired man who looked tired and careworn on the day we visited. The weight loss "does not pose a danger," he said.

Although many aspects of the U.S. military's handling of detainees during the war on terror have been justly criticized, it remains a point of pride among medical workers, security staff, and military leaders at Guantanamo that there have been no deaths among Camp Delta prisoners. Clearly, Hood hopes to maintain that record. "I will not allow them to do harm to themselves," he told us. The military's policy of tube feeding prisoners on hunger strike is controversial, and military health care providers are "screened" before deployment to Guantanamo "to ensure that they do not have ethical objections to assisted feeding," Edmondson told me. The World Medical Association declared in 1975 that prisoners who refuse food and whom doctors consider capable of understanding the consequences should not be fed artificially, and British authorities allowed hunger-striking members of the Irish Republican Army to starve to death in prison in 1981. Yet civilian doctors in U.S. federal prisons are permitted to order the force-feeding of hunger strikers, and some lawyers representing Guantanamo detainees concur with the policy of "assisted feeding" (as military officials prefer to call it) if it is judged medically necessary.

Ethicist Jonathan Moreno of the University of Virginia suggested in an interview that the ethi-

Courtesy of the Department of Defense, Staff Sgt. Stephen Lewald, U.S. Army.

cal issues involved are complex. Detainees at Guantanamo, who are imprisoned in an isolated environment far from their families for an indefinite period, may not have the autonomy needed to make an informed decision to starve themselves. Moreno also noted that the military doctors, nurses, and medics responsible for the care of detainees have a strong interest in keeping them alive, which may render them unable to assess objectively the motives and decision-making process of hunger strikers.

Hood and others at the prison maintain that these detainees are merely protesting their confinement and are not suicidal. Their evidence: most prisoners have submitted quietly to the insertion of nasogastric tubes and have not tried to pull them out. One prisoner threatened to fight and was put into six-point restraints, only to swallow the nasogastric tube without incident. Edmondson said that small, soft, flexible, 10-French tubes are always used, with lidocaine jelly and gargle for local anesthesia. Both he and Hood strenuously denied press reports that large-gauge tubes have sometimes been inserted, without anesthetics, as a punishment. "In none of these [cases] have I ever gotten the impression that these guys want to die," Edmondson said.

Nevertheless, the force-feeding has become the latest issue in an ongoing debate among medical professionals and ethicists about practices at Guantanamo — a debate that has also covered the use of psychiatrists and psychologists to monitor military interrogation of prisoners, the reported use of information from detainees' medical records to plan



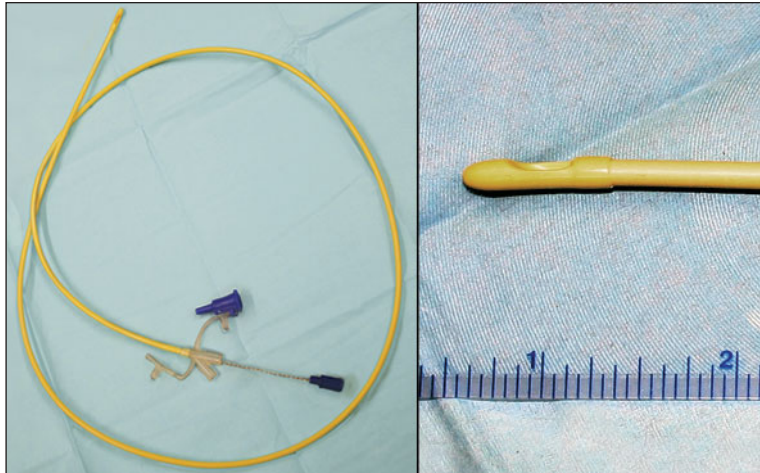
Department of Defense Photograph of Detainees and Guards at a Medium-Security Facility at Guantanamo Bay, Cuba.

interrogation strategies, and other issues. Moreover, our visit came at a time of intense public, judicial, and congressional scrutiny of the Bush administration's policies regarding the legal and moral status and treatment of suspected terrorists. The Senate had recently passed an amendment by Senator John McCain (R-Ariz.) to the defense appropriations bill, prohibiting cruel, inhuman, or degrading treatment of prisoners in U.S. custody, and President Bush was threatening to veto the measure. The military's policies regarding detainees were being revised, with Defense and State department officials reportedly arguing for the incorporation of language on prisoners' rights from the Geneva Conventions and the White House vigorously opposing this change. It seemed evident that one reason for inviting us to the detention center was to try to improve Guantanamo's public image.

Perhaps permitting us to talk with hunger strikers would have undermined that goal. Whatever the reason, the eight tube-fed

patients remained invisible. And the ninth patient — who was he? No one told us, but I have wondered in recent weeks whether he might have been Jumah Dossari. According to news reports published last month, Dossari, a 26-year-old prisoner captured in Pakistan who has been in U.S. custody for almost four years, tried to commit suicide on October 15, four days before our visit. His American lawyer, who had been meeting with him until a few minutes before Dossari's suicide attempt, discovered him dangling from a noose in a cell, his right arm gouged and bleeding. Dossari had reportedly complained of abuse and mistreatment at the hands of U.S. soldiers in Afghanistan and at Guantanamo and had previously attempted suicide. According to a military spokesman, as of November 1, 2005, there had been 36 suicide attempts by 22 Guantanamo detainees.<sup>1</sup>

Allegations of abusive and inhumane interrogation techniques at Guantanamo have been widely publicized, and our group was particularly concerned about the



**10-French Dobhoff Nasogastric Tube.**

According to the military, this type of soft, flexible tube is used for the tube feeding of hunger-striking detainees at Guantanamo.

possible involvement of health care professionals in the mistreatment of detainees. We questioned Hood and others at Camp Delta about interrogation techniques and the role of psychologists or psychiatrists serving on the Behavioral Science Consultation Teams (BSCTs), who observe interrogation sessions and advise interrogators and guards about getting detainees to cooperate. A confidential report by the International Committee of the Red Cross, received by the U.S. government in July 2004 and subsequently leaked to the media, had charged that some techniques used were “tantamount to torture” and stated that medical personnel, through BSCT members, had provided interrogators with information about prisoners’ psychological vulnerabilities.<sup>2</sup>

The Army released a report this past July detailing incidents that had occurred at Guantanamo between 2002 and 2004 in which interrogators used such techniques as frequent sleep disruption, prolonged exposure to loud music and strobe lights, exposure to extremes

of temperature, “short shackling” of detainees in a fetal position, sexual taunting by female interrogators, and the use of military working dogs for intimidation.<sup>3</sup> The U.S. Army Field Manual on intelligence interrogation specifically recommends that an interrogator “be aware of and exploit the source’s psychological, moral, and sociological weaknesses.”<sup>4</sup>

Hood and other officials acknowledged that harsh interrogation techniques had sometimes been employed but said they are not currently in use, even though techniques such as manipulating temperature and other environmental factors, trying to provoke intense feelings of fear or futility, and altering sleep patterns are among those currently permitted at Guantanamo by the Secretary of Defense. Esteban Rodriguez, a civilian responsible since mid-2003 for overseeing interrogations as director of the Joint Intelligence Group, said that of four controversial techniques requiring the secretary’s advance approval, the only one for which approval had been requested during his tenure

was isolation. (The others are attacking or insulting a detainee’s ego, using a “Mutt and Jeff” team of friendly and harsh interrogators, and taking away religious items such as the Koran as a punishment.<sup>5</sup>)

According to the Army report released last July, Hood discontinued the practice of sleep disruption during interrogations when he took command in early 2004. “I’m not interested in stressing anybody,” Hood said. “The most valuable interrogation efforts have occurred . . . by building a rapport over time.” He also told us that interrogators under his command are not given access to information from detainees’ medical or psychiatric records. “Medical care has no connection to intelligence gathering,” Hood said. “Zero. None.” However, BSCT psychologists said that for safety reasons, they are sometimes informed if a detainee has a medical condition such as diabetes or heart disease that might cause symptoms during an interrogation session.

Hood said the majority of interrogation sessions focus on more than 100 detainees considered to have high intelligence value, many of whom are thought to have been mid-level operatives for Al Qaeda. Many of these detainees, as well as some of Camp Delta’s most violent prisoners, are held in Camp 5, a maximum-security prison that has modern interrogation wings, electronically wired so that analysts or other observers can watch interrogation sessions remotely. Detainees are kept in single cells, apparently segregated from other prisoners to a much greater degree than in the other camps. We were not shown Camp 5. Dr. K., a military psychiatrist and internist who runs the

prison's behavioral-science service, told us that someone on her staff sees each detainee in Camp 5 about every two weeks, "to make sure they are doing OK."

We spoke with Dr. H. and Dr. D., the two psychologists who currently serve on Guantanamo's three-member BSCT. The BSCT psychologists are part of the Joint Intelligence Group and do not provide mental health care to detainees. Their role is to observe interrogation sessions and provide feedback to interrogators, as well as advise guards on managing detainees' behavior. "We don't advise [interrogators] on how to up stress," said Dr. H. "Those kinds of techniques do not work; they are not effective. Rapport building . . . is really what we try to emphasize."

Dr. H. said that she had undergone Survival, Evasion, Resistance, and Escape (SERE) training, a military program designed to teach trainees how to withstand abusive treatment and interrogation if they are taken prisoner. Some people familiar with the program have suggested that SERE-trained BSCT psychologists may have used the experience to help design coercive interrogation strategies. Military officials told us they had found no evidence that this has occurred. As a result of SERE training, "I now have a better appreciation of what detainees are exposed to," said Dr. H. "We are never taught any kind of techniques whatever" for harsh interrogation.

But many observers remain concerned about the potential misuse of SERE training, as well as the larger ethical and medical ramifications of involving psychologists and psychiatrists in interrogations. "Empirically, it would be very easy for people with that

kind of training to import their work into other arenas," said Georgetown University ethicist Nancy Sherman, an authority on military culture who was a member of the group visiting Guantanamo. "The role of a psychologist on the other side of a one-way mirror — advising, consulting, helping build rapport — is extremely slippery."

In recent months, organizations for mental health professionals have been trying to set ethics guidelines for their members. This past June, a task force of the American Psychological Association concluded that "it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information-gathering processes for national security related purposes," although they should not "support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment." Last month, the assembly of the American Psychiatric Association endorsed a statement that psychiatrists should not participate in or serve as consultants for the coercive interrogation of prisoners, involving methods such as degradation, threats, isolation, imposition of fear, humiliation, sensory deprivation or excessive stimulation, sleep deprivation, exploitation of phobias, and infliction of physical pain such as prolonged stress positions.

Psychiatrist Steven S. Sharfstein, the president of the American Psychiatric Association and a fellow visitor to Guantanamo, said there is consensus in his association that psychiatrists should not be involved in the interrogation of detainees at Guantanamo or in Iraq or Afghanistan. "There is great concern about when you

depart from your physician role," he said. When a forensic psychiatrist examines a prisoner in a civilian jail, the psychiatrist first explains to the prisoner that the interview may not be to his benefit, and the prisoner is allowed to refuse. "With the detainee situation, there is none of that," Sharfstein said. "The process of interrogating detainees is, by its very nature, deceptive, and that's a major problem. . . . People have to interrogate, but it's really inappropriate to use psychiatrists."

Department of Defense policy states that detainees in military custody should receive medical care similar to that provided to U.S. soldiers. For one Guantanamo detainee, that meant bringing in a team to perform coronary catheterization and place stents; for another, it required bringing in a thoracic surgeon to remove an anterior mediastinal thymoma. Other specialists are available at the naval hospital on the base. A prosthetist visits quarterly to care for detainees who are missing parts of limbs. The hospital has a mini-ICU and two negative-pressure laminar-flow rooms for patients with communicable diseases.

Medical corpsmen screen detainees' medical problems and dispense daily medications. "We try to handle most minor medical problems on the block," Edmondson said. "It takes two guards to transport a detainee to the clinic," located in Camp 1. Some detainees are followed for chronic medical problems such as hypertension, coronary disease, diabetes, hyperlipidemia, and latent tuberculosis. As of October 19, 135 operations had been performed at Camp Delta. At first, most surgery involved treating wounds and removing shrapnel; now, opera-

tions such as hernia repairs, cholecystectomies, and appendectomies make up the bulk of the surgical caseload. Dr. O. told us that the demand for medical care has doubled in recent months, from an average of 2000 patient contacts per month last spring and early summer to an average of 4000 patient contacts per month during the late summer and fall. He added that inpatient volume had increased 10-fold (presumably because of the hunger strike) and that four members had been added to the medical team.

With some detainees approaching the end of their fourth year at Camp Delta, mental health is an increasing concern. Adjoining the detention hospital is a new psychiatric unit containing 16 inpatient cells, recently completed at a cost of \$2.65 million. Edmondson told us that 15 percent to 18 percent of detainees arrived with mental illness and that 6 to 8 percent are followed by mental health professionals. Dr. K., the director of the camp's behavioral services, said that there were four patients in the unit on the day we visited and that 40 detainees were seen regularly, for diagnoses including personality disorder, adjustment disorder, schizophrenia, and schizoaffective disorder. "The majority are appreciative of our care," she told us. "They let us know if they are having problems with sleep or depression." However, she added, fundamentalist Muslim detainees had on occasion refused to speak

with her because she is a woman. "There is a lot of resistance to psychiatric care in the population we're working with," she said.

Kristine Huskey, a lawyer with a Washington, D.C., firm representing 11 Kuwaiti detainees at Guantanamo, said in an interview that some of her clients had complained about their medical care. "Often, the only medical person who comes around is a corpsman," she said. "They complain that they want to see the doctor, and they don't get to. . . . I know that some of my guys have really serious health issues. I know they're not getting the care." She added that two of the firm's clients were debilitated by a hunger strike and were being tube fed; another had been advised by doctors at Guantanamo to have an operation but distrusted their recommendation. In other settings, "when patient-doctor issues become complicated, you get second opinions" or consult an ethics committee, Huskey said. "These guys don't have any of that."

With no opportunity to see patients or speak with detainees, our group was in a position somewhat analogous to that of journalists "embedded" with U.S. military units. Although I learned much from the visit, I continue to juggle contradictory versions of the realities of Camp Delta: confident assertions by Hood and other officers that all treatment of detainees is humane, for example, contrast with statements

by detainees, made through their lawyers, that it is not. Meanwhile, reports by the only objective observers with broad access to detainees — teams from the International Committee of the Red Cross that visit Guantanamo regularly — are not released to the public. As one of my fellow travelers, Georgetown's Sherman, observed the week after the trip, "I came home with cognitive dissonance."

As we were preparing to board the jet at the end of our visit, Hood assured us once more that the military is trying to "do the right thing" at Guantanamo. He left us with a parting challenge: "All those who contend that what we are doing is not right should propose an alternative."

An interview with Dr. Okie can be heard at [www.nejm.org](http://www.nejm.org).

Dr. Okie is a contributing editor of the *Journal*.

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