Mounting evidence from many sources, including Pentagon documents, indicates that military interrogators at Guantanamo Bay have used aggressive counter-resistance measures in systematic fashion to pressure detainees to cooperate. These measures have reportedly included sleep deprivation, prolonged isolation, painful body positions, feigned suffocation, and beatings. Other stress-inducing tactics have allegedly included sexual provocation and displays of contempt for Islamic symbols. The International Committee of the Red Cross (ICRC) and others charge that such tactics constitute cruel and inhuman treatment, even torture.

To what extent did interrogators draw on detainees’ health information in designing and pursuing such approaches? The Pentagon has persistently denied this practice. After the ICRC charged last year that interrogators tapped clinical data to craft interrogation strategies, Defense Department officials issued a statement denying “the allegation that detainee medical files were used to harm detainees.” However, an inquiry led by Vice Admiral Albert T. Church, the inspector general of the U.S. Navy, concluded: “While access to medical information was carefully controlled at GTMO [Guantanamo Bay], we found in Afghanistan and Iraq that interrogators sometimes had easy access to such information.” The implication is that interrogators had no such access at Guantanamo and that medical confidentiality was shielded, albeit with exceptions. Other Pentagon officials have reinforced this message. In a memo made public last month, announcing “Principles . . . for the Protection and Treatment of Detainees,” William Winkenwerder, the Assistant Secretary of Defense for Health Affairs, said that limits on detainees’ medical privacy are “analogous to legal standards applicable to U.S. citizens.”

But this claim, our inquiry has determined, is sharply at odds with orders given to military medical personnel — and with actual practice at Guantanamo. Health information has been routinely available to behavioral science consultants and others who are responsible for crafting and carrying out interrogation strategies. Through early 2003 (and possibly later), interrogators themselves had access to medical records. And since late 2002, psychiatrists and psychologists have been part of a strategy that employs extreme stress, combined with behavior-shaping rewards, to extract actionable intelligence from resistant captives.

A previously unreported U.S. Southern Command (SouthCom) policy statement, in effect since August 6, 2002, instructs health care providers that communications from “enemy persons under U.S. control” at Guantanamo “are not confidential and are not subject to the assertion of privileges” by detainees. The statement, from SouthCom’s chief of staff, also instructs medical personnel to “convey any information concerning . . . the accomplishment of a military or national security mission . . . obtained from detainees in the course of treatment to non-medical military or other United States personnel who have an apparent need to know the information. Such information,” it adds, “shall be communicated to other United States personnel with an apparent need to know, whether the exchange of information with the non-medical person is initiated by the provider or by the non-medical person.” The only limit this policy imposes on caregivers’ role in intelligence gathering is that they cannot act as interrogators.

The statement, embedded — along with policies on parking and alcohol — in the personnel section of the SouthCom Web site, not only requires caregivers to provide clinical information to military and Central Intelligence Agency interrogation teams on request; it calls on them to volunteer information that they believe might be of value. It thereby makes them part of Guantanamo’s surveil-
lance network, dissolving the Pentagon’s purported separation between intelligence gathering and patient care.

Rather than being consistent with the presumption of confidentiality that applies to Americans even in prisons, the Guantanamo policy rejects this presumption. Within military prisons, personal health information cannot be given to correctional or law-enforcement officials unless they deem it necessary for health, safety, or security reasons. Confidentiality is also the starting point in federal and state prisons for civilians, albeit with similar exceptions for health, safety, and security. (Federal law permits disclosure of inmates’ health information “to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.”) There is debate over the scope of these exceptions, but there is consensus about the basic presumption of medical privacy.

Wholesale rejection of clinical confidentiality at Guantanamo also runs contrary to settled ethical precepts. Medical privacy is not an ethical absolute — caregivers in civilian and military settings have an obligation to report information to third parties when doing so can avert threats to the health or safety of identifiable persons — but confidentiality is the starting premise.

The laws of war defer to medical ethics. Additional Protocol I to the Geneva Conventions provides that medical personnel “shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics.” Although the protocol has not been ratified by the United States, this principle has attained the status of customary international law. International human rights law (most important, the 1966 International Covenant on Civil and Political Rights) provides additional protection for privacy in general — in wartime and peacetime. Although this protection isn’t absolute, exceptions must be justified by pressing public need, and they must represent the least restrictive way to meet this need. Wholesale abandonment of medical confidentiality hardly qualifies, especially when the “need” invoked is the crafting of counter-resistance measures that are prohibited by international law.

In what ways did military intelligence personnel draw on medical information for interrogation and counter-resistance purposes? Instructions to Guantanamo veterans not to discuss their service publicly have been an obstacle to answering this question. But available documents, an account of a fall 2004 briefing by the camp’s commander (Brigadier General Jay Hood), and interviews with behavioral science professionals enable us to assemble parts of this picture.

During the camp’s early months, interrogators could gain access to personal health information (and did so to set limits on practices that might put detainees’ health at risk) but did not use psychological assessments of individual subjects. Conventional army intelligence doctrine has been unsympathetic to such input: it has relied instead on a mix of standard interrogation methods meant to appeal variously to subjects’ insecurities, pride, and fears, within constraints set by the laws of war.5 But by late 2002, growing frustration with the slow pace of intelligence production at Guantanamo led to calls from commanders for innovative tactics. Major General Geoffrey Miller, who took command of Guantanamo in late 2002, approved the creation of a “Behavioral Science Consultation Team” (BSCT, pronounced “Biscuit”) in order to develop new strategies and assess intelligence production. A principal BSCT function was to engineer the camp experiences of “priority” detainees to make interrogation more productive.

A psychiatrist and a psychologist staffed the Guantanamo BSCT. Those initially assigned to this team both came from health care backgrounds; neither had much training in behavioral analysis of the sort that civilian psychologists perform for law-enforcement agencies. According to Hood’s briefing, BSCT consultants prepared psychological profiles for use by interrogators; they also sat in on some interrogations, observed others from behind one-way mirrors, and offered feedback to interrogators. The first BSCT psychologist, Major John Leso, a specialist in assessing aviators’ fitness to fly, attended part of the interrogation of Mohammed al-Qahtani, thought by many to be the “20th hijacker.” (An extract from a log of this interrogation published in Time magazine last month refers to Leso as “Maj. L.”)

There are strong indications that the Guantanamo BSCT has had access to personal health information. An internal, May 24, 2005, memo from the Army Medical Command, offering guidance to caregivers responsible for detainees, refers to the “interpretation of relevant excerpts from
medical records” for the purpose of “assistance with the interrog- 
gation process.” The memo, pro-
vided to us by a military source, 
acknowledges this nontherapeu-
tic role, urging health profes-
sionals who serve in this capacity to 
avoid involvement in detainee 
care, absent an emergency. This 
aknowledgment is consistent 
with other accounts of informa-
tion flow from caregivers to be-
havioral science consultants to 
interrogators.

Competing behavioral science 
models have influenced the ad-
vice given to interrogators by 
BSCT members. One approach 
emphasizes fear and anxiety as 
counter-resistance tools; another 
favors rapport with detainees. 
The former approach, supported 
by some associated with the John 
F. Kennedy Special Warfare 
Center who have helped to formu-
late BSCT doctrine, builds on the 
premise that acute, uncontrolla-
able stress erodes established be-
havior (e.g., resistance to ques-
tioning), creating opportunities 
to reshape behavior. Complex re-
ward systems (e.g., the creation of 
multiple camp “levels” with 
different privileges) promote co-
operation. Stressors tailored to 
the psychological and cultural 
vulnerabilities of individual de-
tainees (e.g., phobias, personal-
ity features, and religious be-
liefs) are key to this approach 
and can be devised on the basis 
of detainee profiles.

Proponents of rapport-based 
interrogation counter that an-
swers given under high stress 
are unreliable. Not only are peo-
ple in acute distress inclined to 
say whatever they think might 
bring relief; the psychiatric se-
quela of extreme stress — anx-
xiety, depressed mood, and disor-
dered thinking — impair the 
understanding of questions and 
produce incoherent answers. Rap-
port building, tailored to peo-
ple’s cognitive styles and cultural 
beliefs, takes time but yields 
better information, its defenders 
contend.

There is no scientific answer 
to the question of which inter-
rogation strategy is more effec-
tive. For obvious ethical and legal 
reasons, there is unlikely to be 
one. At Guantanamo, the fear-
and-anxiety approach was often 
favored. The cruel and degrad-
ing measures taken by some, in 
violation of international human 
rights law and the laws of war, 
have become a matter of nation-
al shame.

Clinical expertise has a lim-
ited place in the planning and 
oversight of lawful interroga-
tion. Psychologists play such a 
role in criminal investigations, 
and medical monitoring of de-
tainees is called for by interna-
tional law. But proximity of health 
professionals to interrogation settings, even 
when they act as caregivers, car-
rries risk. It may invite interro-
gators to be more aggressive, be-
cause they imagine that these 
professinals will set needed lim-
its. The logic of caregiver involve-
ment as a safeguard also risks 
putting health professionals in 
ever more deeply. Once caregiv-
ers share information with in-
terrogators, why should they re-
frain from giving advice about 
how to best use the data? Won’t 
such advice better protect de-
tainees, while furthering the in-
telligence-gathering mission? And 
if so, why not oversee isolation 
and sleep deprivation or monitor 
beatings to make sure nothing 
terrible happens?

Wholesale disregard for clin-
cial confidentiality is a large leap 
across the threshold, since it 
makes every caregiver into an 
accessory to intelligence gather-
ing. Not only does this under-
mine patient trust; it puts pris-
oners at greater risk for serious 
abuse. The global political fall-
out from such abuse may pose 
more of a threat to U.S. security 
than any secrets still closely held 
by shackled internees at Guanta-
namo Bay.

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www.nejm.org

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