

MEDICAL EVIDENCE OF TORTURE BY U.S. PERSONNEL



July 24, 2008

**Briefing of the
Commission on Security and Cooperation in Europe**

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ABOUT THE ORGANIZATION FOR SECURITY AND COOPERATION IN EUROPE

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The OSCE Secretariat is in Vienna, Austria, where weekly meetings of the participating States' permanent representatives are held. In addition, specialized seminars and meetings are convened in various locations. Periodic consultations are held among Senior Officials, Ministers and Heads of State or Government.

Although the OSCE continues to engage in standard setting in the fields of military security, economic and environmental cooperation, and human rights and humanitarian concerns, the Organization is primarily focused on initiatives designed to prevent, manage and resolve conflict within and among the participating States. The Organization deploys numerous missions and field activities located in Southeastern and Eastern Europe, the Caucasus, and Central Asia. The website of the OSCE is: <www.osce.org>.

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The Commission on Security and Cooperation in Europe, also known as the Helsinki Commission, is a U.S. Government agency created in 1976 to monitor and encourage compliance by the participating States with their OSCE commitments, with a particular emphasis on human rights.

The Commission consists of nine members from the United States Senate, nine members from the House of Representatives, and one member each from the Departments of State, Defense and Commerce. The positions of Chair and Co-Chair rotate between the Senate and House every two years, when a new Congress convenes. A professional staff assists the Commissioners in their work.

In fulfilling its mandate, the Commission gathers and disseminates relevant information to the U.S. Congress and the public by convening hearings, issuing reports that reflect the views of Members of the Commission and/or its staff, and providing details about the activities of the Helsinki process and developments in OSCE participating States.

The Commission also contributes to the formulation and execution of U.S. policy regarding the OSCE, including through Member and staff participation on U.S. Delegations to OSCE meetings. Members of the Commission have regular contact with parliamentarians, government officials, representatives of non-governmental organizations, and private individuals from participating States. The website of the Commission is: <www.csce.gov>.

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JULY 24, 2008

PARTICIPANTS

	Page
Hon. Alcee L. Hastings, Chairman, Commission on Security and Cooperation in Europe	1
Erika B. Schlager, Counsel for International Law, Commission on Security and Cooperation in Europe	10
Leonard Rubenstein, J.D., President, Physicians for Human Rights	1
Allen Keller, M.D., Bellevue/NYU Program for Survivors of Torture	4
Scott A. Allen, M.D., Advisor to Physicians for Human Rights	12

APPENDICES

Prepared statement of Hon. Alcee L. Hastings	21
Prepared statement of Leonard Rubenstein	22
Prepared statement of Allen Keller	26
Prepared statement of Scott A. Allen	35

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Commission on Security and Cooperation in Europe Washington, DC

The briefing was held at 2 p.m. in room 311 Cannon House Office Building, Washington, DC, Hon. Alcee L. Hastings, Chairman, Commission on Security and Cooperation in Europe, moderating.

Panalists present: Hon. Alcee L. Hastings, Chairman, Commission on Security and Cooperation in Europe; Erika B. Schlager, Counsel for International Law, Commission on Security and Cooperation in Europe; Leonard Rubenstein, J.D., President, Physicians for Human Rights; Allen Keller, M.D., Bellevue/NYU Program for Survivors of Torture; and Scott A. Allen, M.D., Advisor to Physicians for Human Rights.

Mr. HASTINGS. Ladies and gentlemen, I welcome you to the Helsinki Commission's briefing with representatives for Physicians for Human Rights.

As Chairman of the Helsinki Commission, I know that raising human rights issues is a two-way street. As Soviet dissident Andrei Sakharov once observed, the Helsinki Final Act only has meaning if it is observed fully by all parties. I quote, "No country should evade a discussion of its own domestic problems, nor should a country ignore violations in other participating States."

The point of the Helsinki Final Act is mutual observation, not mutual evasion.

Gentlemen, good doctors, I have a full statement. I'm going to include it in the record. But I really am more interested in hearing from you than I am from me.

So if we could start with Dr. Rubenstein, I would appreciate it.

And I might add, ladies and gentlemen, their biographies as well as their full statements and other offerings are on our table outside.

So, Doctor, thank you all so very much for being here.

Mr. RUBENSTEIN. Thank you, Congressman, and thank you for this opportunity to participate in this hearing and—this briefing—and thank you for holding the briefing.

My colleagues and I will be discussing the findings and recommendations of a recent report by Physicians for Human Rights entitled "Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and its Impact."

We have copies on the table if you don't have one.

Physicians for Human Rights is an organization that for more than 20 years has employed medical and scientific methods to document violations of human rights so that truth can be determined and perpetrators held accountable.

For these two decades, we have engaged in these medical evaluations throughout the world and led the process that led to international standards for such examinations contained in the manual on effective investigation and documentation of torture and other cruel, inhuman and degrading treatment or punishment, which is known as the Istanbul Protocol.

And for the past 5 years, we have been engaged in investigations and analysis concerning interrogation methods used by the United States to determine whether the United States itself engaged in torture or cruel, inhuman or degrading treatment and punishment.

“Broken Laws, Broken Lives” is the third report we have released.

Let me begin by—about the report by giving you a little bit of context. Over the last 4 years, as a nation, we have increasingly learned about the process by which extremely harsh interrogation methods, such as isolation, stress positions, sleep deprivation, sensory deprivation, severe humiliation and many more, were authorized and adopted, first, by the CIA and then by the Department of Defense.

What has been missing from this picture, though, is an understanding of the consequences of the decisions made about the interrogation methods on thousands—and I emphasize—thousands of human beings who came into custody of the United States, only a tiny handful of whom have been charged with any crime.

And we’re especially concerned with the period before any public disclosure, which was 2001 to 2004.

Often this discussion had an abstract quality, though torture and cruel treatment are anything but abstract. They result in searing pain and suffering and rob people of humanity.

So we decided we had to found out what happened to some of the victims.

To do this, we identified 11 men who were formerly in U.S. custody and who were willing to undergo intensive 2-day medical and psychological evaluations under the standards of the Istanbul Protocol, which I mentioned a moment ago.

The sample was not random, but we did not exclude anyone who agreed to participate.

Four of the men were arrested or brought to Afghanistan and then sent on to Guantanamo. The other seven were held in Iraq, most in Abu Ghraib. All were eventually released and none were charged with a crime.

What we found across the board was the men experienced a horrible stew of methods of torture and ill treatment that brought about intense pain, degradation and suffering. And it’s suffering that endures to this day.

As always happens when governments start down the road to torture, intelligence gathering gave way to a regime of cruelty that destroyed many of the men.

There were five major findings I’d like to summarize. And Dr. Keller will describe the experiences of some of the men he, who was one of the evaluators, examined.

First, in all the locations, almost all the men were subject to a combination of the kinds of techniques I mentioned a moment ago that were authorized by the Defense

Department at various times, including isolation, stress positions, suspension, extremes of heat and cold, severe humiliation, use of dog and threats.

In Iraq, almost all of the men were forced to be naked for very long periods of time, often while isolated in cold, dark rooms and cells.

In Guantanamo, 3 of the 4 men reported being shackled to the floor for 18 to 20 hours at a time.

Also in Guantanamo, men were forced to take drugs without being informed of what they were or why they were being administered.

Second, all the men reported that the experience of being subjected to these and other techniques were on an intense level of physical pain and agony.

Former detainees describe the inability to move their muscles for 18 hours or being suspended by their arms as excruciating. A number of them loss consciousness during the process when they were being placed and kept in these stress positions.

Psychological pain and suffering where thought, if anything, worse. They experienced despair, fear, and terror from being kept alone, often naked in lightless, cold rooms, from being exposed to excessive loud noise, from fear of dogs, from worrying about threats to their families, from the constant degradation and humiliation, and from the very disorientation and agony brought on by lack of sleep.

Seven of the men contemplated suicide despite the Muslim prohibition on suicide. One of them attempted suicide multiple times. Others simply wished for death.

For some, the severity of the psychological abuse also led to physical symptoms, including chronic headaches, chest pains, and difficulty breathing.

Third, we found that all the men's suffering lasted for years after release.

As I mentioned, these men were in custody between, most of them, between 2001 and 2004, though some were released later.

But they continue to suffer physical pain in joints, limbs, and muscles.

And the horror most of all lives on in their minds. They can't sleep. They experience nightmares. They're severely hampered in their social and family relationships and in their work. They feel like their lives have been shattered.

And from a medical standpoint, the diagnosis of severe depression, anxiety and post traumatic stress disorder were common.

Fourth, we found that the authorized techniques, many of them themselves amount to torture, begot yet additional forms of torture, proving once again that once torture starts, it cannot be contained. What I mean by this is that beatings became intense and common.

Particularly in Afghanistan, but also in Iraq, one man lost multiple teeth. Another had to be hospitalized.

Two and possibly three men in Iraq were sodomized. Two men in Iraq were subjected to electric shock. And a third was shocked when pushed into a generator.

And in Iraq particularly, there was an environment of gratuitous cruelty.

One man was suspended by a winch, another stabbed in the cheek with a screwdriver.

Fifth and finally among our findings or key findings, medical personnel played a very problematic role.

Now some of the detainees reported receiving good medical care. And sometimes medical personnel intervened to stop abuse.

But others reported instances where medical personnel became cogs in the system of abuse, sometimes by sharing medical information, sometimes by turning a blind eye to abuse, and sometimes by patching up people so abuse could continue.

The medical record which we obtained in one case shows that the medical personnel saw a man severely decompensated become psychotic and suicidal. It was very clear that this treatment to which he was being subjected, including isolation, contributed to his decompensation. But they didn't address that cause and, in fact, told the man at one point, when he begged to be removed from isolation, that that's a decision the interrogators could make. There was no evidence that the doctors or medics reported abuse.

Now, in 2006, the Army repudiated most of these forms of torture, although the new Army interrogation manual continues to allow isolation and sleep deprivation, limited—sleep limited to 4 hours for certain detainees. So they—these methods have not completely been eliminated by the Department of Defense. And of course the CIA has eliminated—hasn't eliminated any of these.

So our first recommendation is for a firm prohibition on torture and ill treatment, including all the techniques and methods we found.

Second, we think there has to be accountability. As elsewhere in the world, we need to have the truth.

Despite the investigations and hearings and many reports, we still have only a small glimpse of what thousands of men experienced. So we are calling for a full, independent, nonpartisan commission with subpoena powers to get access to documents and to personnel's testimony. And this also should include the role of medical personnel.

And I should add that for the past 3 years, Physicians for Human Rights has asked the Defense Department for an internal investigation of the role of medical personnel and abuse. And we've never had a response.

Of course, accountability must also include prosecutions for war crimes.

As General Taguba said in the preface in our report, "those who committed these crimes should be held responsible."

Finally, we believe the government owes the victim. That begins with apology but also compensation and also access to rehabilitative services that torture victims deserve.

And finally, in setting future policy, we have to talk not just about ticking bombs, but about what happens to human beings when a regime of torture unfolds.

Mr. HASTINGS. Thank you.

Dr. Keller?

Dr. KELLER. Thank you, Congressman. Thank you so much for holding this briefing today, which clearly has relevance to our interactions with other countries and diplomatic relations and other things. And I believe nobody gets that better than this Commission. So I thank you for holding this hearing today.

I was one of the medical evaluators in this study. And the 11 evaluations of former Abu Ghraib and Guantanamo detainees that my colleagues and I conducted, we found clear physical and psychological evidence of torture and abuse, often causing lasting suffering.

As a physician with over 15 years of experience in caring for victims of torture and evaluating them from all over the world, I can tell you that—the torture and abuse that these men endured tragically is second to none.

Let me share with you two examples.

First, a gentleman identified as Yusuf. He is in his early 30s and, unable to find work in his homeland, he went to Afghanistan. Subsequently, he tried to go home and as he was trying to go home, he was detained at the Afghan-Pakistan border, then transferred to the detention facility, the U.S. detention facility in Kandahar. There he was immediately interrogated, beaten. He was stripped. The first night, he wasn't allowed to sleep because guards would hit the detainees and throw sand at them.

While at Kandahar, he endured forced nakedness, intimidation by dogs, hooding, repeatedly being thrown against the wall. And he was subjected to electric shocks from a—from a generator, as Len had alluded to.

Subsequently, he was transferred to Guantanamo where, during the long flight, he was shackled to the floor of the plane. And the tight cuffs caused his wrists to swell.

Upon arrival at Guantanamo, he was initially kept at Camp X-Ray, where he described the conditions of confinement as horrific. They were extremely hot outdoor cages with only a bucket for a toilet.

Lengthy interrogations, accompanied by sleep deprivations. Small infractions, such as speaking with other detainees, led to beatings. And a person who he believed was a physician checked the injuries of the detainees after the beatings.

Three months later, he was transferred to Camp Delta where he said the conditions, at least in the prison cells, were better. However, the interrogations and being held in the interrogation rooms, which happened every other day, were quite brutal.

Although he denied being beaten while held in the interrogation room—again, this speaks to how we assess credibility. You know, you're—you're looking—when an individual was candid with you when they were treated well and when they weren't treated well, what physical symptoms they do and what they don't have. So it's from that overall impression. And I should say, on average, we took close to 1, 1½ to 2 days per individual to conduct these detailed physical, psychological evaluations.

So back to Yusuf. While he was held in this interrogation, he was chained to the floor and forced to assume stressful positions. Ice water was poured on him. At other times, loud music was played. Sometimes they would make the temperature in the room very hot, other times very cold. There was someone, again, who he thought was a physician that would come and monitor his vital signs, clearly a violation of medical ethics. And on no occasion did the hot or cold stop after the good doctor paid his visit.

Demands for confessions were constant and they were accompanied by the interrogator's threatening him.

For example, his brother suffered leukemia and the interrogators told him, "Your brother's been arrested." And the soldiers also threatened to shoot him.

Humiliation was a routine part of the interrogations. He was forced to watch pornography. Soldiers tore the Koran apart in front of him.

And he described an incident in which a naked woman entered the interrogation room and smeared what he believed to be menstrual blood on him.

At one point while at Camp Delta in Guantanamo, Yusuf asked to speak to a psychologist because of the sadness that he was feeling from separation from his family. He believes the psychologist shared this information with his interrogators, who exploited it by threatening him with spending the rest of his life in Guantanamo.

Following this interrogation, he was then moved to the worst section of Camp Delta where he wasn't allowed to have a blanket or a mattress.

He was later released after he signed a—a form of—of what he said was a false confession. And this was in the fall of 2003.

So while Yusuf acknowledged to us that he experienced symptoms of depression before his detention, the symptoms that he described afterwards were far more disabling and chronic.

He also now suffers from post traumatic stress. He has described difficulty functioning and has not found steady employment since his—his detention. In short, he's a shell of who he was.

The next individual I'd like to tell you about is a man referred to in the report as Amir, who was detained in Abu Ghraib. He is in his late 20s. He was a salesman before being arrested by U.S. forces in Iraq in 2003.

After his arrest, he was shackled, forced to stand naked for over 5 hours. For the next 3 days, he and other detainees were deprived of sleep and they were forced to run for long periods, during which time he injured his foot. When he pointed out this injury to a soldier, the soldier pushed him up against a wall and he lost consciousness.

Later, he was transferred to Abu Ghraib. And at first, he acknowledged that he wasn't mistreated, but then the abuse began. He was subjected to religious and sexual humiliations, hooding, sleep deprivation, restraints for hours while naked and dousing with cold water.

The most horrific incident that Amir recalled was that he was placed in a foul-smelling room, forced to lay down in urine and then was sodomized with a broomstick and forced to howl like a dog while a soldier urinated on him. After a soldier stepped on his genitals, he fainted.

In July 2004, he was transferred to Camp Buka where he said he wasn't abused and then subsequently released.

And it was really striking, in all of these evaluations, that the points the individuals became almost the closest to tears wasn't necessarily when they were describing the physical abuse, but the sexual humiliations—was where, you know, they would hang their head and often become quite emotional, that, and the uncertainty of when and if they would be released.

And so Amir continues to experience physical symptoms, including significant pain consistent with what he reported.

On physical, he had multiple scars on his body, including on his head, his legs and his penis. This is consistent with what he described.

Psychologically, he suffers debilitating symptoms of post traumatic stress, disturbed sleep, anxiety, sexual dysfunction.

He's changed from a stable provider for his family to an unemployed man. Though the stresses related to the war in Iraq may well exacerbate his symptoms, he clearly understands that his most debilitating symptoms are attributable to his torture and

sexual violations. And as he put it, quite emphatically, quote, “No sorrow can be compared to my torture experience in jail. That is the reason for my sadness.”

The individuals evaluated for this study were subjected to a variety of dangerous and harmful forms of abuse, often simultaneously. And these are referred to as benign, quote, “enhanced interrogation techniques,” such as stress positions, sleep deprivation, sexual humiliations.

From a medical and a scientific perspective, there is nothing benign about these methods and they should be seen for what they are, gruesome, dehumanizing, dangerous. They are torture and they cause lasting physical and psychological harm.

So in conclusion, I would say this. We must ensure that torture and mistreatment, no matter what you call it, are neither condoned, nor take place under our country’s watch.

Though perhaps invoked, albeit misguidedly, in the name of national security, the abuses committed by the United States have undermined our integrity and, I believe, have made the world a much more dangerous place.

We must take responsibility for what has happened, as Len alluded to, and see that it never happens again.

Thank you.

Mr. HASTINGS. Thank you very much.

Dr. Allen, I think you heard that bell, but I’m going to try to stay to hear your testimony if I can.

Mr. ALLEN. Well, thank you Congressman. And I will make an extra effort to make my comments particularly brief.

My colleagues both made reference to the issue of health professional participation in torture. As a former correction physician, or in common parlance, prison doctor, these issues are of great concern to me. And I just want to make some brief remarks regarding them.

Now, there’s a number of ways health professionals can participate in abuse and torture. They can design techniques, as shocking as that sounds. They have done that. They can monitor those techniques. They can participate directly. They can fail to intervene to stop it. They can fail to document a report up the chain of command or outside the chain of command. And they can treat and return a victim to the setting of torture.

Perhaps the most perplexing and worrisome is this idea of direct participation of health professionals, physicians and psychiatrists in particular.

And I just want to bring out two examples that are slightly beyond the scope of this report, but I want us to keep them in mind.

The first is the setting of a hunger strike. And the issue there, of course, is the use of forced feeding.

And the second related issue is the use in various settings of forced medication.

The central ethical issue that—that is at play in both forced feeding of hunger strikers against their wishes and forced medication of detainees against their wishes is violation of the issue of informed consent.

Informed consent is that process whereby a patient is informed of the risks and benefits of a procedure understands why it’s in their best interest or can help them either diagnostically or therapeutically.

Unless it sounds like a mere formality, think of any exam that you have undergone yourself, whether it's a dental exam, whether it's a pelvic exam, whether it's a prostate exam, and think of the difference between giving your informed consent for that process to continue, in which case it's uncomfortable, but it's either therapeutic or diagnostic and minimally traumatizing. Imagine any of those procedures progressing without your consent.

So the very fact that physicians have been placed in positions where they've been asked to engage in invasive procedures against the consent or against the express rejection by the patient is deeply disturbing and of concern to be as a physician. We should not be asking our—our uniformed professionals to engage in such activity.

So I'm just going to make those very brief comments now to put those issues on the table and turn it back over.

Thank you.

Mr. HASTINGS. I can't really thank you enough for the piercing testimony and your report.

Several questions come to mind. Regrettably, I won't be able to put them. But Ms. Schlager will be here and will ask the questions that I would have asked.

Just for your references, if you would—first, your recommendations are outstanding. I will scour the legislative terrain to see if any of it is already a part of legislation or is in draft to be.

And the one thing, the independent commission study, I certainly would—if it—if it does not exist, then I will talk with Senator Cardin and other members of the commission, particularly Congressman Smith. And I think that we would file such a request.

Additionally, you had access to medical records. And that's something in an ongoing trail that seems to be an issue of the one person who has been tried. And I would be curious if you can share with us how you accessed those records. And if you cannot, then I certainly understand that as well.

I and Senator Cardin and Representative Smith have spent a considerable amount of time on this subject. We began Helsinki around this year at CSCE with an unusual kind of hearing in that we had not done much domestically. And we went to the University of Maryland and the subject was torture. And we had colleagues of yours, mostly from academia—not to suggest that all of you are not from academia—but they were more oriented from that standpoint.

As a lawyer, I can just share with you that I'm personally disappointed that you would even have to examine 11 individuals.

I certainly am mindful that 11 persons is not a comprehensive enough study. I would be curious to know if you extrapolate that, what it would look like, in your opinion, with the thousands of other people that have likely been subjected, particularly in Afghanistan and Iraq.

We know the precise numbers in Guantanamo. We don't know the precise numbers that have been skirted off to—to unidentified locations and countries that we know that do commit torture. And yet, we subjected those persons to that kind of undertaking and black sites and stuff.

I served on the Intelligence Committee and oversight is of no use because nobody will tell you the truth. When I got to Guantanamo, all I got was a dog and a pony show. And I'm absolutely certain, just as an observer and a person that did an awful lot of work in

prisons as a judge and then as a lawyer representing prisoners and fighting against this kind of thing domestically that takes place long before many of our laws did improve it considerably.

That's just a long way of saying to you what my short feeling is—is that I appreciate your courage. I appreciate your insight. And indeed, all of—of—of the recommendations that you offer in this report will be taken seriously by this commission. And I can assure you that we can manifest it in some form of legislative undertaken.

And I believe, without speaking for him—which I would never speak for a Member of the other body—but I do believe that Senator Cardin would share much of my sympathies that I've expressed.

Gentlemen, I thank you.

I'm fond of saying—staff that works with me gets tired of hearing me say it, but the truth is it's hard to apologize for working. So I have to go and vote.

And I thank you.

And if you would stay, Ms. Schlager will continue the briefing.

Mr. RUBENSTEIN. We can begin by answering some of Congressman Hastings' questions. I'll speak and then Allen can join me.

On the question of medical records, we—[off mike]—on the question of medical records, these were all released detainees. And one of the lawyers—the lawyer for one of the detainees succeeded in getting the record through the Freedom of Information Act. And then the detainee consented to share those records with us.

For current detainees, getting access to medical records is far more difficult, really impossible. And the Defense Department has to date denied any request for any independent medical evaluations.

We actually suggested to the Defense Department a joint evaluation in which Defense Department physicians and independent physicians jointly do examinations so there was consensus about what the finding was. But that has not been allowed.

We think it really is important that these records see the light of day because they shed a lot of light on what happened to people.

On the question of extrapolation, the report states that we can't generalize from 11 cases. And the 11 cases weren't random.

What we can't say is what we found was quite consistent both with many of the policies related to interrogation and related to detention methods and reports of other observers, including the FBI, including reports from General Church and others. So we think that that consistency allows us to draw some conclusion that—that it would not be a surprise to find that other detainees suffered similar conditions.

You want to add?

Dr. KELLER. Sure.

So first, I agree wholeheartedly with what Len said in terms of the need to evaluate the medical records. And there have been some very disturbing examples. And Dr. Allen can speak to this better than I of clear falsification of medical records, covering up deaths, for example.

In terms of how many people were arrested, for example, in Iraq, I—I think we don't know the answer to that. What we do know is that, often, individuals were arrested in these sweeps where basically everybody within a certain radius was just arrested.

And perhaps there were some, you know, very bad individuals among those. But there were an awful lot of people who were just in the wrong place. And that was a theme that seems to recur, even through these—many of these individuals whom we spoke with. So we really don't know the answer to that. But it's chilling.

And I actually have recently heard—interviewed one of the military who was involved in these sweeps and voicing his own concerns about how many people they wrongfully arrested, putting them in a system where there was absolutely no mechanism for, you know, a fair process, let alone the hellacious conditions under which they were held.

And just one aside with Abu Ghraib, I think it's naive, at best, malicious, at worst, to think that this was, quote, "a couple of bad apples on the night shift."

So with regards to extrapolating what we learned from these 11 individuals, what does this tell us about a—a larger pattern of U.S. behavior of the individuals. Clearly, it's not a random sample and it's a small one.

I will say, it's frankly very, very difficult accessing former detainees. And certainly, I would welcome the opportunity to go and do an independent, random study of detainees at Guantanamo or Abu Ghraib if we were ever given such access. But given that we're not, this was the best that we could do.

That said, these individuals were detained in multiple places—Kandahar, Abu Ghraib, Guantanamo, at least two or three other prisons. And so the patterns of abuse, of the sexual humiliations, of the forced standing, these—again, this ridiculous term, quote, "enhanced interrogation techniques," a sanitized word for torture—were methods that we heard, you know, over and over, be it at Kandahar, at Guantanamo, or Abu Ghraib.

Now clearly, in Abu Ghraib, in terms of the conditions of the cells, you know, being filthy with feces and urine, you know, that, you know, was a whole other—other—other level.

But I think from this report one can at a minimum say this does support the hypothesis that these abuses were not random, were not isolated and that seems methodical and part of a pattern.

And I think that's why, as Len said, it's crucial—crucial—that we have a clear accountability.

I'll just say, as a doctor who cares for torture survivors from around the world, I am really worried that we have made this world so much more dangerous for the student activist in Africa or the Tibetan monk by what we have done. And I think it's going to take us years to undo the damage we've done. So we better get started.

Ms. SCHLAGER. Thank you.

I'd like to ask a followup question, again, bearing in mind that this is a limited sample—and I'm sorry, we'll come back, Dr. Allen, with several questions. But I'd like to stick with this for just 1 second.

Do you have a sense to what extent abusive treatment was directly related to information or intelligence gathering and to what extent it had a life of its own?

Mr. RUBENSTEIN. It's both. There—There is no question that in the development and approval process for methods that were designed to disorient and create dependence, techniques like sleep deprivation, isolation and other psychological methods, those were clearly related to interrogations. In fact, the standard operation procedure manual for Guantanamo, which was leaked back last fall, which was 2004, it basically says—it says

in black and white, in the first 30 days, people will be kept in isolation for the purpose of creating disorientation and dependence. So many of these methods were quite deliberate. And then, they do take on a life of their own.

When abuse and dehumanization is tolerated, it inevitably leads to worse. And that's what we say. That's how you end up with beatings and worse.

That the lack of control and the sense on the ground—the soldiers on the ground, that they—that they were supposed to break these people down, does end up removing restraint and so a whole new dimension begins. That's what we think the dynamic was.

Dr. KELLER. I would add to that, that, yes, I think it did start with a misguided assumption that this was an important part of intelligence gathering.

Actually, in the film by the same name as the manual, a documentary, "Standard Operating Procedures," where a number of the soldiers who were in Abu Ghraib, you know, they commented how they would be specifically told by the interrogators, "OK, this prisoner should have a bad night. Make sure they have a bad night," which meant they wouldn't sleep or they'd be subjected to horrific—horrific things.

And, you know, what was clear in Abu Ghraib is you had—and I believe in Guantánamo as well—this phenomena of what I call moral disengagement, that individuals may somehow contextualize what they're doing as part of a greater good. And they rationalize what they're doing, such as the psychologist who is in the room monitoring the interrogation and misguidedly thinks, "Well, I'll serve as a buffer," whereas really they probably serve more as an enabler. And so the abuse, as Len said, I think intensifies.

And it's really—the ironic thing is, you know, and again, what we've learned, where did these procedures come from? We, you know, learned from the best, from, you know, a manual from the Chinese that I believe was entitled, "How to Extract False Confessions." So these methods were never intended for getting at the truth. What they were intended was getting confessions.

You can get—you know, and one interesting thing, having spent a lot of time over the past year talking with professional interrogators, you know, there was something I found in common with science is saying, "Garbage in, garbage out," that they would say, "Look, we can get anybody to say whatever—whatever they want."

And then I also think that this language is so important. That somebody may say, well, as our former Secretary of Defense said, "Well, gee, I stand for, you know, I stand for 4 hours a day. What's so wrong with that? Have them stand for 8 hours." Well, there's a profound difference between somebody standing by choice, who is actually moving around, versus somebody standing in one place for several hours, where the blood begins to pool. The legs swell. You can develop clots, which can go to the lungs and potentially be life—life threatening.

Sleep deprivation, another of our Presidential candidates said, "Hey, I'm sleep deprived. I don't think this is torture." Again, a difference between a Presidential candidate with lots of comforts, I'm sure, although I don't doubt they're fatigued, versus somebody who has no idea when they're going to sleep again.

And after being deprived of sleep, you become paranoid. You develop symptomatic symptoms, headaches, dizziness. You have delusions. Not a—not a good recipe for useful information.

So it does start as information gathering perhaps, but then I think it takes on a life of its own.

But it came—it's important to realize it wasn't random. It was manualized.

Mr. ALLEN. If I could just add again from my perspective of 7 years working full time in a prison, there's an old study that we all point back to, and every one should be reminded of, the Stanford Prison Experiment. And it described the tendency of good people to do bad things when put in a setting when they have absolute power and control over another population. That phenomena is only enhanced when the population is demonized across a cultural barrier or a language and then certainly in a war situation.

So from our perspective, we see these settings as tremendously high risk for abuse, which is why it is all the more important to have operating procedures that go out of their way to draw a bright line and—and make it clear that human dignity must be preserved.

Now, in this case, as my colleagues have already made blatantly clear, it was from the top level that said, "No, we're not going to do that. We might have our reasons why we're not going to do that." But that opened the door. And once that door is open, these tendencies of abuse, which are deeply ingrained unfortunately, are allowed to come forth.

Ms. SCHLAGER. Dr. Allen, I'd like to stay with you for a minute and go back to one of the issues that you touched upon, and that is the question of forced feeding.

There—there was a period of time after the Guantanamo Detention Facility was opened that there were no deaths at that facility. And this was something that was sometimes mentioned by U.S. officials at briefings. And I think they pointed to that as evidence of some level of care that was afforded to the detainees, that there had been no deaths at Guantanamo.

However, in 2006, two Saudi detainees and one Yemeni detainee hanged themselves.

And in 2007, a Saudi detainee was found dead in his cell. To my knowledge, there are no details about that particular case. But there have been four—at least four deaths.

At one point, we also know or believe from reports, that there was a very large number of hunger strikers. One report in May 2006 suggested as many as 75 detainees, which out of a prison population of several hundred is quite a large percentage, maybe 75, were on hunger strikes.

Subsequent to that, we started to get reports that the procedures used to engage in force feeding were quite harsh.

And I'm wondering if you can tell us something about the norms that apply for medical professionals? I do understand that the International Criminal Tribunal for the Former Yugoslavia allowed one detainee to be force fed, one detainee before the court who was refusing to eat.

So what's the norm that's at play? And then, beyond the specific norm, when that norm is being implemented, is there something about the way that—are there different methods of force feeding and some are more humane than others or some are less humane? Thank you.

Mr. ALLEN. Well, there's a lot in that. And I'll try to address all your points. Feel free to redirect me if—if I don't.

The history of the use of force feeding at Guantanamo and its possible relationship to subsequent suicides is a very provocative question, something I've wondered about. And it speaks more to the context in which hunger striking occurs.

Remember, and in particular, if you wanted to design an environment that would increase the risk that there would be hunger strikes, they could not have done a better job than Guantanamo.

The standard on how to manage hunger strikes, the ethical standard, has been articulated and recently updated for the World Medical Association. And that position is—has been adopted by the American Medical Association. And that guideline is explicitly clear that under no circumstances would you force feed a competent and informed detainee who is refusing nourishment after having been, you know, informed of the potential consequences.

Now, that seems like an odd thing for a medical, ethical group—physician to take because obviously it could be at the odds with the duty to preserve life. But it is a position that has been formed by years and years of looking at an experience—having experience and talking to people who have managed hunger strike situations. That it realizes that these really true-to-the-end hunger strikes generally only occur in situations where there are no other mechanism for the individual to protest their conditions of confinement or to assert their autonomy over their own body and their own health. So that's a very important value to be preserved.

And again, medical bodies have recognized that even though the duty to preserve life is a preeminent medical value, it does not trump a competent individual's right to make an autonomous decision about their own health.

So a couple of things appear to have happened over the course of management of hunger strikes at Guantanamo. One, as you note, they started to happen with increasing frequency and with larger numbers of individuals.

You know, this—at one point, one of the camp commanders refers to this as asymmetrical warfare. This is a situation where you have a—a—a group of detainees who are so disempowered—it seems like an absurd notion. Clinically speaking, that's entirely absurd. To me, it says there's increasing desperation among the detainees and that was a reflection of it.

What they started doing is increasingly using forced feeding and very possibly, although we have yet to nail this down, intervened with forced feeding before it was clinically indicated.

Now, to the extent that there's some controversy about WMA and preservation of life versus autonomy, there is no controversy about the idea of forcing the feeding tube down someone's nose, through their esophagus, strapping them down to a chair or a table and pouring nutritional supplements through that tube when it is not medically necessary. So there is some question whether that has been done at the direction of a camp commander directing medical staff to intervene before it would be medically indicated. And if that happened, that's just such a clear violation that—that's not even in the same category.

Ms. SCHLAGER. Thank you.

I'd like to go back to Dr. Keller with a different question.

When you're interviewing or—I'm not sure what the proper term is for when you're examining these individuals and you're trying to determine what's happened to them—it seems that some of the medical or psychological problems they may suffer now could potentially have been caused by preexisting conditions. And it seems that that must be a very difficult thing to sift through. And I'm wondering if you could elaborate a little more on how you figure out what was caused—even when you find real problems, how

do you determine what was caused by the conditions they experienced during their detention and what came before that?

Dr. KELLER. Right. Well, so first, we have, as Len alluded to, an invaluable roadmap, arguably the gold standard with which to conduct these evaluations, specifically the Istanbul Protocol, a document recognized by the United Nations, which was the product of, I think, over 30 or may even 50 experts in the field of torture working for several years on developing standards on how such evaluations should be done.

So first, it all starts, you know, with a very detailed history. And, you know, one, we had the good fortunate of having time. As I said, for each of these evaluations we had both a medical and a mental health professional conducting the interviews. And it was often over the course of 2 days so that you had the opportunity if there was something, you know, that hadn't made sense or what have you that you, you know, can go back to them. And like everything else, the longer you spend with someone, the more of a sense you get about what they have.

And one thing that I was very struck by with everyone I interviewed frankly was their candor. You know, that individuals were very clear about what mental health problems, for example, that they had, which is nothing something necessarily even that, you know, the Muslim population would be forthcoming in talking about. But that there was, you know, one individual who had told us about, yes, in fact, had some suicide attempts before he was arrested. And this one individual I described describes some feelings of sadness. So similarly with scars with—and I would do these—we would do these detailed histories and then do a very detailed review of physical symptoms, a review of psychological symptoms, a review of—you know, then a lengthy physical examine.

And individuals were quite candid that, "Oh, yeah, well, this scar, you know, I got from when I was playing soccer as a young boy. This one I'm actually not sure about. This one I'm sure came from, you know, XYZ."

So it's frankly—it's contextual in that it's the overall picture from which one makes their assessment, you know, based on the consistency, based on their candor, their affect, and then what—does it make sense?

You know, my wife, who is a former prosecutor, said that's always the important question, you know, does what they're saying make sense. And, you know, is it consistent with what you're finding.

I mean, if somebody pointed, as I have had in some cases, you know, to where it's clearly a vaccination scar and said, "Well, you know, I got this, you know, from where they burned me with a cigarette," that, you know, is problematic.

But I just was struck by the candor, struck by the affect, struck by the fact, again, that, you know, I think arguably the least likely population I could think of, based on my years of work with torture survivors before this, of being candid about sexual humiliations is a Muslim male population. So it was—and actually, it was really—really the most difficult part.

And I must say, you know, as we—the—the 100 pound or 500 pound gorilla in the room was that there were Americans sitting across the table. And so, you know, there—took some time for some rapport building. And frankly, good interrogators will tell you that that's what it's all about, you know, frankly, whether you're doing an interrogation or whether you're doing a medical evaluation, in terms of rapport building.

So I don't know if that—

Ms. SCHLAGER. It does. And I would like to ask a followup question. Your testimony indicated that some of these individuals really needed to be referred for additional treatment afterwards, after—based on what you observed.

And as you know, the former Chairman of this Commission, Congressman Smith, was the original author of the Torture Victim's Relief Act. And many of the Commissioners have supported that as well and supported funding for torture treatment centers in the United States and around the globe.

And I'm wondering if you have any observations on the adequacy of care that's available to these individuals now.

Mr. ALLEN. Well, first, I must start by really just acknowledging Congressman Smith's and the late Congressman Lantos' and other's extraordinary leadership on what really was a bipartisan movement to—to sponsor the Torture Victim's Relief Act, which provides for funding for torture treatment centers in the United States, such as our own. And there's a consortium now of more than 20 centers around the country, the National Consortium of Torture Centers, many of whom are funding through this.

And it's estimated that there are over 400,000 torture survivors here in the United States. And tragically, the world being the way it is, we're very busy. We have, I think, right now, 70 people on our waiting list.

The Torture Victim's Relief Act also provides for international funding, one directly and then also through the United Nations Voluntary Fund for Victim's of Torture.

So I actually think that both on the—the good news is that there is funding out there. The unfortunate thing is has clearly been inadequate.

The Torture Victim's Relief Act is funded right—has been pretty much steadily funded at around \$10 million a year. And now, it's at the point where I believe it—it's authorized, you know, for, you know, being up to \$20 million. But what gets allocated is consistently \$10 million. And that's woefully inadequate.

And so I think being true to the spirit of the Torture Victim's Relief Act, that, yes, now being in the uncomfortable position of having been the perpetrators of this abuse, we have a moral responsibility, as Len stated, to acknowledge this, to investigate this, to apologize and to make sure that individuals have access.

I mean, pretty much all the individuals that I saw—there was one individual who frankly had had, you know, quote, “the least benign treatment,” who was emotionally in tact, I would say. Pretty much everybody else that I evaluated, you know, as I said, were shells of who they were and really needed physical and psychological services.

Some individuals that we evaluated, we actually were able to refer to centers and others we were sending back into an abyss where there were no services, so in Iraq, the former Guantanamo detainees. Unfortunately we have created a lot of need for torture treatment programs.

Ms. SCHLAGER. Thank you.

I'd like to throw this next question open. Clearly, your report suggests that there are medical personnel that did not report on mistreatment that they witnessed, and there may have been medical personnel who went beyond that and, in some way, played a role in the mistreatment. And related issue of particular import, I think, are the reports on the waterboarding of three detainees. Some of those public reports have suggested there may have been medical personnel waiting in the wings.

And I guess I'd like to hear you all speak a little bit more to the question of what those medical professionals should have been doing. I think, at one point, it's indicated in the report that it—it—there's no evidence in the cases that you looked at that any of these medical professionals reported anything to anybody.

At what point should they have done that? At what point is it—do medical personnel say, "I can't. I have to remove myself"?

Mr. RUBENSTEIN. First, to clarify on the reporting, we didn't have access to—to whatever abuse reports were filed. What we did have access to in the medical record was there was no evidence in the medical record that you would have thought would be found there if they had reported it.

So it was like one case that we—we are confident that it wasn't reported.

The standard is very clear that—that physicians and other medical personnel cannot play any role whatsoever in torture, including being present. And that—that's included because—of two reasons. One, not to be able to help interrogators calibrate the amount of harm that's being imposed. And that's the problem with the behavioral science consultation teams, where the role is to calibrate harm.

And the second reason is they're not supposed to patch people up so they can be tortured some more. And that's what we think happened.

House professionals were in a difficult, conflicted position in these facilities because they were working in an environment where people were being subjected to torture and ill treatment. And you do have a responsibility as a physician to—and other medical personnel, to provide care, but you can't be in a position of providing care so that torture can continue.

There was the case of a man whose shoulder, I think, was dislocated. And it was put back and then back in a stressed position.

So that is where they were in the worst possible position.

Now, there were some who may actually have played a more extensive role, like in waterboarding, where they are really part of the apparatus of making the torture take place.

But I think, far more common, it was that they were on the scene to patch people up and they had no support. And they thought of themselves, we think, as to be expected to provide care.

And so the only thing they can do is report, protest and—and demand—protest the treatment and demand it stop and that they will not have anything to do with patching people up. And that is a point of leverage.

And health professionals in the military have a little more autonomy than other soldiers, so that they could have spoken up. But it's not—it's taking themselves out of the apparatus, which is the key.

And you may want to comment as well.

Mr. ALLEN. Well, I think what I'd like to add to that is this issue of—the role of health professionals does go beyond what Len was just talking about. We do have evidence now, particularly psychologists who helped design and—and develop these techniques. And so, you know, that was going far beyond failing to stop and intervene. So I just do want to mention that the scope of participation was broader.

And the way that was achieved bureaucratically, so to speak, was that the certain health professionals were assigned outside the care domain and then were told, “You don’t have to answer to traditional medical ethics. The guidelines, even in the Defense Department, but more likely in the CIA, created this new domain of health professional that, if not assigned to direct care, was not answerable to medical ethics. So I do want to make mentioned of that.

But back to the issue of the health professionals assigned to the care teams, my—my concern is—well, first of all, a big caveat. We don’t know the full story of whether some health professionals did actually intervene. If so, we’re not aware of a single episode.

Interestingly enough, although this is all very shrouded in secrecy, we are aware of non-professional soldiers intervening to stop torture and some—and, in some cases, some lawyers. So it seems to me that after years of the profession expressing dismay that no doctors or medics or psychologists, or, you know, psychiatrists intervened, it seems to me, if there was a case, by now, it would have been trumpeted out and then talked about and then, you know, used as an example of good behavior. So I’m concerned that that has not come to light.

But the caveat is we don’t have a full record.

The last thing I’d like to say about that is to go back to Congressman Hastings’ point about trying to have oversight when you can’t get a straight answer and tie it back to the use of medical records.

You know, a lot of what we do is sort of forensic medical work. The medical record, if it can be obtained in a proper manner, such that there’s proper consent and confidentiality is protected, might be one of the best pieces of information, as it’s a standardly written, chronological record of what happened to these individuals. So that’s something—the answers to exactly what health professionals did are recorded somewhere. And at some point, that should be looked at.

Dr. KELLER. I’d just like to add a couple of things from some of the individuals whom I interviewed that speaks to the question of, OK, what does medical participation mean.

So first, as was alluded to, developing techniques. And, you know, there—there are a group of psychologists who, quote, “developed or used these methods had been used, you know, in the SERE training methods and then misapplied them. Arguably, they pilfered, plagiarized, whatever term you want to use, from the Chinese manual.

And apparently, these individuals, my understanding of the psychologists that were involved in that, were not really not individuals who had particular expertise in this area, but suddenly were put in this area of having authority and kind of went with it.

Among the individuals I evaluated—I mentioned one, this very chilling example of the—a Guantanamo detainee who had described several ways that doctors were involved. One, you know, when he was in Camp X-Ray, he described what he called robo cops on parade, you know, when there would be some—they would do something wrong. Someone would be having their hands under the blanket or whatever and that the—you know, the military guards, you know, in their armor, would march out and beat them up. And at the end of the parade was somebody they believed was a physician with a gurney there, you know, just to—you know, just in case, and kind of check things out.

But—and I asked the question, “Well, you know, did they ever hear that individual speak up.” And they said no.

And the same thing I heard from Abu Ghraib detainees. There was one individual who I interviewed, who had been detained in a dark cell and who was claustrophobic and terrified. And he was, actually, as a punishment, forced to stand outside of his cell naked for several hours. And you know it's bad when that becomes your respite period because, when they went to put him back in the cell, he actually pleaded with a physician who was walking by. He said, "Please don't have them put me back in the cell." And the physician, I guess, asked a guard. But then said, "Oh, sorry, you know, you've got to go back."

That case of the physician monitoring the vital signs of the individual in this room where it's very hot or very cold—that's similar to what's been documented with waterboarding, for example, in Argentina. I'm not so sure about the medical participation in waterboarding here. None of the individuals we evaluated reported waterboarding.

But, you know, there again, not in a therapeutic setting, but really, you know, kind of to measure or, you know, whatever, push to the limit, but not—but not kill them.

And then the violations of confidentiality. There have been clear reports of sharing information, you know, so that weak spots could be extrapolated. And I, first hand, heard an example of that from this psychologist—from this individual who reported that when he'd asked to speak to a psychologist, he'd spoke to somebody who identified themselves as a psychologist. Their name, I believe, was taped over. But, you know, and talked about how lonely, and how much he missed his family. And he said, you know, he'd been interrogated like every day, every other day, and they asked the same questions. And the next day after he spoke with that psychologist, the questioning took a totally different, you know, turn, zeroing in, as it hadn't before, on that issue of him missing his family. And, you know, that's what they kept at. And then they moved him to this—this—this area where it was even worse.

So, and then finally, you know—all—as has been pointed out, it's a clear violation of medical ethics to, in any way, practice or condone any torture and that health professionals have a positive responsibility to report this.

There's debate with interrogations and being present. The out wire is the American Psychologist Association. All the other professional societies have said, "Health professionals don't have a place in an interrogation." Whereas, the American Psychology Association, although there's a lot of debate and argument—their meeting, I think, is at the end of August, so I think it will be a pretty interesting one about that. But they, so far, as an organization said, "No, there is a place."

And from my understating of what's happened in Guantanamo, for example, they really aren't—you know, they think maybe, you know, we're there as containing the situation. But I think what happens is the—the health professional there is like, well—you know, they're there at the behest of the military so they're like, "Well, maybe I can wait a little longer." And the interrogator or whoever is thinking, "Well, if I cross the line, they'll stop me." And so the two enable.

And then the last thing I'll say is, having actually spoken to some health professionals whom I've known who've worked in Guantanamo, I remember there was one thing someone told me that I was really struck by, which is that he said, "You know, in Guantanamo, we learned that everybody stays in their lane." And to me, that almost became—you know, what I was hearing was hear no evil, see no evil, you know? And so, and I asked, you know, "Well, did you find any evidence of torture." He said no. I said, "Well, did you look for it? Did you ask?" And, you know, there was kind of a shrug.

Ms. SCHLAGER. Before I bring this briefing to a close, I'd like to ask you if you have any final comments to make. And then I'd like to make two observations of my own. But if you—if you have any final thoughts you'd like to share——

Mr. RUBENSTEIN. Well, I would first like to thank the Commission again for—and Congressman Hastings for holding this briefing.

I think it's really important to recognize that these issues have not been sufficiently explored.

And in particular, it struck me as we're having this conversation that this is the first discussion in any official congressional activity of the medical participation issues.

So when people say we've looked into this enough, we haven't at all.

And so I'm both appreciative of this hearing, want to emphasize that there's much, much more we need to know.

Dr. KELLER. What I'd like to add to that, yes, also is extraordinary gratitude for holding this briefing.

And, you know, I came initially scratching my head a little bit about, OK, why is the Helsinki Commission doing this? And, you know, I really get it because they—they understand it. I mean, what have we wrought by what we've done?

Ultimately, we've violated the Golden Rule. You know, for years, we told the Turks, we told the Soviets, we told whoever not to do this, not to do that, not to, you know, extrajudicially arrest someone, not to torture.

And so what we did was, we said, well, it's not torture, it's enhanced interrogation, you know, and all these other ridiculous things that, at the end of the day, one, in addition to making, you know, it more dangerous for those, you know, innocent civilians—and it's important to know, most torture victims aren't terrorists or terrorist suspects. They're, you know, student advocates. And it's never really about—or, you know, people seeking freedom. It's never about information. It's about quieting and intimidating. So we've made the world more dangerous for them.

But I also think in terms of the international policy level, which, you know, clearly the Helsinki Commission understands, it's made a much more difficult row for us to hoe.

How can we hold others accountable? How can we possibly condone this when we have done these things? And so that's why it's so crucial that, you know, better late than never that we take the high road and that we say, OK, these things happen. We're going to investigate it. We're going—there's going to be accountability. It's not just a white-washing of, well, a few bad apples on the—on the night shift.

So accountability is—is—is crucial. It's not as simple as, well, let's just put this behind us. Because unless we really examine this and document and—to have accountability, it will never be behind us.

And then, I am left with thinking that tragically there is, I fear, going to be an even greater epidemic of torture. It's documented to occur in 100 countries now. I think what we have done has empower—emboldened—not that Robert Mugabe, for example, needed any excuses. But I think I have—he has been quoted as saying, “Well, you know, look, the U.S. does this.” And so on and so forth.

National security is what's always or often invoked in the name of torture. So I think we've made it a lot easier for despots to do what they want to do. So I fear we're going to see a lot more torture survivors.

And again, that goes back to an issue that Congressman Smith and others have led on, which is that I think there's going to be a much greater need for increased funding to care for torture survivors, one, who have suffered at our hands and, two, who were victims because, you know, there's more torture probably going on now because of these emboldened depot regimes.

Mr. ALLEN. I had the opportunity, with PHR, earlier this year, to travel to Libya to examine one of their leading dissidents and political prisoners to verify, A, that he was still alive. And our goal was to try to protest his treatment and conditions. And we had to confront the officials of Khadafy's government about his treatment. And we were immediately told in response, "Who are you to say anything about how we treat somebody in our custody? We haven't done any of the things that you have been alleged to do as part of official policy."

You know, I think that it's obvious to all of us that we've done great damage to ourselves.

As a physician, it disturbs me that we've done potentially great damage to our profession and our standing. And medicine is based on the practice of trust. And when detainees can no longer trust their physicians, providing medical care in detention settings will be and is impossible.

So I think the important thing is to thank you for allowing us to talk about this issue.

I think there's an understandable denial on the part of the American Government and the American people to not want to think about the fact that we've done bad things. But the only way to repair this damage that we have done is to have an open discussion about what has happened, look at why has happened, document explicitly what has happened, and—and make some revisions on our policies and move forward and correct our path.

Thank you.

Ms. SCHLAGER. Thank you.

I'd like to conclude, first, by thanking each of you for coming down today and participating in this briefing. You bring singular areas of expertise with you. And we have benefited enormously from—from your being here today and sharing that with us.

But second, I'd also like to commend to anyone who has not yet done so the preface to this report written by Major General Antonio Taguba. General Taguba, as my colleagues here remember, was one of the high-ranking officials tasked with investigating the abuse at Abu Ghraib. And his report—his preface to the report describes this as the largely untold human story of what happened.

His preface is short, but very compelling. So with that, and the recommendations, it's a great book end for this report.

And I want to thank all of you for being with us here today. Thank you so much. The briefing is adjourned.

[Whereupon, at 3:20 p.m., the briefing was adjourned.]

APPENDICES

HON. ALCEE L. HASTINGS, CHAIRMAN, COMMISSION ON SECURITY AND COOPERATION IN EUROPE

Ladies and gentlemen, I welcome you to the Helsinki Commission's briefing with representatives for Physicians for Human Rights.

As Chairman of the Helsinki Commission, I know that raising human rights issues is a two-way street. As Soviet dissident Andrei Sakharov once observed, the Helsinki Final Act only has meaning if it is observed fully by all parties: I quote, "No country should evade a discussion of its own domestic problems, nor should a country ignore violations in other participating states." The point of the Helsinki Final Act is mutual observation, not mutual evasion.

When we raise issues with other countries, we'd like to believe our concerns are being taken seriously. Conversely, I believe we need to look seriously at the concerns raised with us.

In recent years, there is nothing that has drawn more attention and criticism in the OSCE Parliamentary Assembly than our treatment of detainees. And our detention policies have been pretty hard to explain or defend.

The fact is, it is not always easy or pleasant to hold a mirror up and look at one's own practices. But that is what we're going to do at today's briefing.

A few weeks ago, Physicians for Human Rights issued a report entitled "Broken Laws, Broken Lives." In it, they document the medical evidence of torture by U.S. personnel. Today, we will hear from representatives from that organization on the findings in their report.

I expect that our witnesses today will describe the medical and psychological impact of this torture on the individuals whose cases were investigated by PHR. But I would like to note briefly that there is a different kind of impact on display this week.

As many people here may know, this week, in Guantanamo Bay, the United States opened its first war crimes trial since World War II. In the trial of a man alleged to be Osama bin Laden's driver, the military judge overseeing the case found it necessary to exclude from evidence several statements of the defendant because they were obtained under what the judge deemed "highly coercive" conditions. Another one of the government's efforts to bring a defendant before a military tribunal has been put indefinitely on hold, reportedly because the evidence in the case cannot be disentangled from the impermissible methods that were used to extract it.

With that so noted, I would like to welcome our witnesses: Leonard Rubenstein is President of Physicians for Human Rights, and he is joined by Dr. Allen Keller, Advisor to Physicians for Human Rights and Director of the Bellevue/NYU Program for Survivors of Torture. Their bios are available here, but I would like to note that Dr. Keller served as a Public Member on the U.S. Delegation to the OSCE in 1998. Dr. Keller, we are grateful for that public service. Finally, we also have with us Dr. Scott Allen, also an Advisor to PHR who worked on this report. Welcome to you all.

LEONARD S. RUBENSTEIN, PRESIDENT, PHYSICIANS FOR HUMAN RIGHTS

Thank you for the opportunity to participate in this important briefing on behalf of Physicians for Human Rights. I am accompanied by two colleagues, Dr. Allen Keller, who is a member of Physicians for Human Rights' Advisory Council and directs the Bellevue/NYU Program for Survivors of Torture; he is one of the physicians who engaged in the detainee medical evaluations which we will discuss today. Also with me is Dr. Scott Allen, a former Medicine as a Profession Fellow at Physicians for Human Rights and now Co-Director of the Center for Prisoner Health and Human Rights at Brown University. My colleagues and I will be discussing the findings and recommendations of a recent report by Physicians for Human Rights entitled *Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and its Impact*.

Physicians for Human Rights is an organization that has, for more than 20 years, employed medical and scientific methods to document violations of human rights so that the truth can be determined and perpetrators held accountable. We have used those methods not only to generate human rights reports but to advance justice through war crimes tribunals for former Yugoslavia, Rwanda, and Sierra Leone as well as truth commissions and domestic courts. It is likely that evidence we obtained from mass graves at Srebrenica will be used in a trial of Radovan Karadzic, who was finally arrested this week. For all of the two decades, we have particularly engaged in medical examinations of torture throughout the world and led the process that led to the adoption of the international standards for such examinations contained in the *Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, known as the Istanbul Protocol. For the past five years we have been engaged in investigations and analysis concerning interrogation methods used by the United States to determine whether the United States itself engaged in torture or cruel, inhuman and degrading treatment or punishment. *Broken Laws, Broken Lives* was the third report we released on actions by the United States.

Let me begin by providing some context for the report. Over the past four years, as a nation we have increasingly learned about the process by which extremely harsh interrogation methods, such as isolation, stress positions, sleep deprivation, sensory deprivation, severe humiliation, and many more, were authorized and adopted—first by the CIA and then the Department of Defense. We have come to understand how the use of these techniques were facilitated by the manipulations of law by the Justice Department and approved by the highest officials of our government. In recent months, new information has emerged about the “re-engineering” of methods used to train American soldiers to withstand torture to use affirmatively on detainees, and even the medieval practice of waterboarding came to be approved and used. We have also learned how officials who opposed the use of torture were marginalized in the policy process.

What has been missing from the picture, though, is an understanding of the consequences of these decisions on thousands of human beings who became detainees in U.S. custody, only a tiny handful of whom have been charged with any crime, especially in the period before any public disclosure, that is 2001–2004. Often the discussion has had an abstract quality, though torture and cruel treatment is anything but abstract. They result in searing pain and suffering and rob people of their humanity. So we decided to find out what happened to some of the victims.

To do this, we identified eleven men formerly in U.S. custody who were willing to undergo intensive two day medical and psychological evaluations of allegations of torture and ill treatment and their severe, long-term physical and psychological effects. The sample was not random, but we did not exclude anyone who was willing to participate. We used the standards of the Istanbul Protocol to engage in the assessment, and in each case we used a team consisting of an internist and either a psychiatrist or psychologist. Four of the men were either arrested or brought to facilities in Afghanistan—Kandahar and Bagram Air Force Base—and then brought to Guantanamo. The others were held in Iraq, most in Abu Ghraib, some of these in the so-called hard site. Each of the former detainees was brought into custody some time between 2001 and 2003. All were eventually released, and none of them were charged with a crime.

These medical evaluations are a key tool because they can reveal physical and psychological evidence of torture such as scars from burns, muscular pain from suspensions, and evidence of rape, and profound symptoms of depression and Post Traumatic Stress Disorder resulting from such torture and humiliation. The evaluations also illuminate the connection between the men's current physical and mental suffering and level of functioning and their experiences in US custody. Finally, they include sophisticated assessments of the credibility of the men's own stories. Moreover, in one case from Guantanamo, we were also able to obtain a 1200 page medical record. We relied on it to gain more information about his experience, compare it to the detainee's story and examine the role of medical personnel.

What we found was that the men experienced a horrific stew of methods torture and ill treatment that brought about intense pain, degradation, and suffering that endures to this day. As always happens when a government starts down the torture road, moreover, intelligence gathering gave way to a regime of widespread cruelty that destroyed many of the men and demeaned the nation.

I'd like to share five major findings from the report and Dr. Keller will describe the experiences of some of the men he evaluated. First, in all the locations, almost all of the men were subjected some combination of the practices authorized at various times during the period of their incarceration: prolonged isolation, stress positions that included suspensions and forced into contorted positions for long periods of time, exposure to extremes of heat and cold, severe humiliation, sensory bombardment (especially incessant deafening noise) and deprivation, use of dogs to instill fear, and sleep deprivation. They were all threatened—some with death, others with rape of their wives, and for Iraqis, with transfer to Guantanamo. Dogs were used to instill fear. There were also some differences:

- Though detainees were forced to be naked for some periods in Guantanamo, in Iraq, almost all the men were forced to be naked for very long periods of time, often while isolated and in cold and dark rooms or cells.
- In Guantanamo, three of the four men we interviewed reported being shackled to the floor for 18–20 hours at a time.
- Also in Guantanamo, men were forced to take drugs without being informed of what they were or why they were taking them.

Second, they all reported that the experience of being subjected to these and techniques brought on an alarming level of physical pain and agony. Former detainees described the inability to move muscles for up to 18 hours following their abuse, or being

suspended by their arms, as excruciating. A number of them lost consciousness in the process. Their psychological pain and suffering was, if anything, worse. They experienced despair, fear and terror from being kept alone and often naked in cold, lightless rooms accompanied only by incessant loud noise; from fear of dogs; from threats to their families from the degradation that was a hallmark of their lives; from the severe disorientation and agony brought on by lack of sleep; and from the incessant taunting and humiliation to which they were subjected. Despite the prohibition in Muslim law, seven of the men we interviewed reported contemplating suicide. One of them attempted suicide many times. Others simply wished for death. For some, the severity of psychological abuse also led to physical symptoms including chronic headaches, chest pain, and difficulty breathing.

Third, we found that the men's suffering has lasted for years after release. They continue to experience pain in joints, limbs, muscles and ligaments. And though free from detention, the horrors from their detention lives on in their minds. Many can't sleep or experience nightmares when they do. Some are terrified of dogs. They are severely hampered in social and family relationships and in their work. All but one felt that their lives have been shattered. Almost all were found to meet diagnostic criteria for severe depression, anxiety disorders and Post Traumatic Stress Disorder.

Fourth, we found that the authorized techniques—many of which themselves amount to torture—began yet additional forms of torture, proving again that once torture starts, it cannot be contained.

- In the facilities in Afghanistan, when men were held before being sent to Guantanamo, beatings were especially severe and often relentless. One man lost multiple teeth as a result of beatings; another had to be hospitalized after losing consciousness. Beatings were also common in Iraq.

- Two, and possibly three men in Iraq, were sodomized.

- Two men in Iraq were subjected to electric shock and a third, in Afghanistan, was shocked when pushed into a generator.

- In Iraq, the men described an environment of gratuitous cruelty. One man was suspended by a winch; another was stabbed in the cheek with a screwdriver.

Finally, medical personnel played a problematic role in these facilities. The detainees were unable to identify names or roles of the medical personnel they encountered because their names were shielded from them, but nevertheless shed light on their role. Some of the detainees reported receiving good medical care for injuries or health conditions and were grateful for it; there were occasions, too, where medical personnel intervened to stop abuse. But others reported occasions where medical care was seriously delayed or denied altogether. Most disturbing of all, they reported instances in which medical personnel were caught up in the abuse, sometimes by sharing medical information with interrogators, sometimes by turning a blind eye to abuse they witnessed, but most often by providing medical interventions whose effect was to allow abuse to continue. In one case, a medic or other medical official put the arm of a detainee that had been dislocated from stress positions back into place, and torture continued. The medical record of a detainee from Guantanamo, moreover, revealed how medical personnel declined to connect the isolation and stress positions that were part of the interrogation regime and his severe deterioration—to the point of psychotic symptoms and multiple suicide attempts. They did nothing to address the source of his decompensation and left to interrogators the decision

whether to remove the detainee from isolation. There is no record in the medical file that they reported any abuse to anyone.

There is a name for what was done to these men and we should not shy from the word because of its power and legal implications. These men were tortured. The practices inflicted on them have been determined to be torture by courts, by international bodies responsible for monitoring torture and by our own State Department Country Reports.

In 2006 the Army repudiated almost all forms of torture and ill treatment these men experienced. The new Army Field Manual on human intelligence collection does, however, continue to allow isolation for up to 30 days and permits limiting sleep to four hours for certain detainees. This should end. The CIA has repudiated none of the practices inflicted on these men. So our first recommendation is for a firm prohibition on torture and ill treatment, including the techniques and methods used on these men as well as other extremely harsh methods employed by any agencies of the U.S. government on detainees in their custody.

Second, there must be accountability. And that process of accountability must begin, as always, with a full understanding of the facts. Despite many investigations and hearings, we have only a small glimpse of what the thousands of men who passed through U.S. custody during this period were subjected to. We have seen only a fraction of the documents that shed light on what happened, and heard from a relative handful of soldiers, contractors and detainees. Interrogation logs remain classified and most medical records have not been released. We believe a full record of what happened is the only way to get at the truth, reveal other lessons, and put policies and mechanisms into place that can prevent a recurrence of these horrors. We therefore urge that a full investigation in the form of an independent, non-partisan commission that has access to all documents and has subpoena power to obtain relevant documents as well as the testimony of officials. I want to emphasize that this must include a full and robust investigation of the role of medical personnel in abuse of detainees. For the past three years Physicians for Human Rights has asked the Defense Department to engage in an investigation of the role of medical personnel in abuse. We have never had a reply.

Accountability must also include prosecuting individuals who have committed war crimes, whatever their place in the chain of command. As General Antonio Taguba states in the Preface to our report, the question is no longer whether war crimes were committed, but whether those who committed them will be held responsible.

Finally, our government owes the victims. To begin, that requires an apology for what was done to them. It also requires some form of compensation and making available rehabilitation services to men who suffered.

Most of all, in setting future policy, we must not just talk about ticking bombs, but talk about what happens to human beings when a regime of torture unfolds.

Thank you very much.

ALLEN S. KELLER, M.D., MEMBER, ADVISORY COUNCIL, PHYSICIANS FOR HUMAN RIGHTS, ASSOCIATE PROFESSOR OF MEDICINE, NEW YORK UNIVERSITY SCHOOL OF MEDICINE, DIRECTOR, BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE

Thank you for the privilege of speaking at this briefing on behalf of Physicians for Human Rights (PHR). My name is Dr. Allen Keller and I was one of the expert medical evaluators for the PHR study “Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and its Impact.”

I am an Associate Professor of Medicine at New York University School of Medicine. I am Director of the Bellevue/NYU Program for Survivors of Torture (PSOT) in New York City and the NYU School of Medicine Center for Health and Human Rights. Since our Program began in 1995, we have cared for approximately 3,000 men, women and children from more than 80 countries. Our Program is a member of the National Consortium of Treatment Programs (NCTTP) and the International Rehabilitation Council of Torture Victims (IRCT). I am a member of PHR’s Advisory Council. I have participated in PHR’s asylum network examining victims of torture and mistreatment applying for political asylum in the U.S. I have also participated in several PHR investigations and studies documenting torture and mistreatment, and training health professionals in conducting such documentation. I have also served as a member of the American College of Physicians Ethics and Human Rights Committee.

In this study, I worked with a group of highly skilled colleagues with substantial experience in evaluating individuals alleging torture and mistreatment. My colleagues and I conducted detailed medical evaluations of former Abu Ghraib and Guantanamo detainees and found clear physical and psychological evidence of torture and abuse, often causing lasting suffering. As a physician with over 15 years of experience evaluating and caring for torture victims from all over the world, I can tell you the torture and abuse these men endured while in U.S. custody are sadly and tragically second to none.

I will briefly discuss two individuals I evaluated for PHR’s report—one from Guantanamo and one from Abu Ghraib. They put human faces to the horrific abuse these former detainees experienced and the devastating health consequences from which they continue to suffer. These 2 individuals also provide chilling descriptions of medical complicity in their torture and abuse.

It is a gross breach of professional ethics for health professionals in any way to countenance, condone or participate in the practice of torture, or other cruel, inhuman or degrading treatment or punishment of prisoners.

The individuals evaluated for this study were subjected to a variety of dangerous and harmful forms of abuse and interrogation techniques, (often simultaneously) several of which have been referred to as seemingly benign “enhanced interrogation techniques.” This includes methods such as stress positions, beatings, temperature manipulation, threats of harm to person or loved ones, prolonged isolation, sleep deprivation, sensory overload, sensory deprivation, sexual humiliation, exploitation of fears and phobias, and cultural or religious humiliation. From a medical, scientific and health perspective, there is nothing benign about these methods. Such techniques are gruesome, dehumanizing and dangerous. They should be called for what they are: torture. Clinical experience and data

from the medical literature are clear. These techniques can cause significant and long lasting psychological and often physical pain and harm.

Many forms of torture and abuse, including the “enhanced interrogation techniques,” may leave no physical scars but can nonetheless cause severe physical and psychological suffering. For example, if someone is subjected to the sexual humiliation of forced nakedness, or a gun is held to their head and the trigger pulled in a mock execution, there may be no physical scars, but the nightmares, the terrors can persist for years after the trauma. According to one recent study published in the medical literature, the significance of harm caused by non-physical psychological abuse is virtually identical to the significance of the harm caused by physical abuse. In a study conducted by our own program, we found that psychological symptoms were significantly higher among those who experienced death threats.

It is important to note that any one form of torture or mistreatment rarely occurs in isolation, but in combination with several abusive methods. The harm caused by the combination is greater than the additive effect of individual techniques. Prolonged isolation, for example, combined with sleep deprivation, exposure to loud noises, and exposure to cold, compound their devastating psychological impact. Furthermore the potential of these techniques to cause harm is intimately related to the context and setting in which they are used. Fear of harm or even death is real, not imagined. Cultural and religious humiliations, and language barriers heighten stress. Such methods are potentially harmful to even individuals who were previously healthy. When used on individuals with underlying health problems, such as heart disease which may or may not be known, they can be potentially lethal for example by causing heart attacks or strokes.

YOUSEFF (FORMER GUANTANAMO DETAINEE)

One individual, whom I evaluated with Dr. Barry Rosenfeld, a forensic psychologist at Fordham University who has worked extensively with the Bellevue/NYU Program for Survivors of Torture, is a former Guantanamo detainee identified in the report as Youseff. It is important to note that Youseff, as with all of the individuals we evaluated, was never formally charged.

Youseff was first in U.S. custody in Kandahar Afghanistan beginning around late 2001. Youseff was interrogated, beaten and stripped naked. He also was subjected to intimidation by dogs, hooding, thrown against a wall, and sustained electric shocks from a generator. Six weeks later he was transferred to Guantanamo. During the flight, he was blindfolded, forced to wear headphones, and shackled to the floor of the plane, causing pain in his wrists, which was later exacerbated by prolonged cuffing and having his handcuffs tugged on while at Guantanamo.

Initially, he was kept at Camp X ray in cages, where guards would come and beat him and other detainees for small infractions such as speaking to other detainees. Someone, whom he believed was a physician was present during these beatings, and did nothing to stop them.

After 3 months, he was transferred to Camp Delta, where conditions were better. He was subjected to frequent interrogations. While being held in the interrogation room, he was shackled for extended periods and subjected to extremes of heat and cold. Someone whom he believed was a physician periodically checked his vital signs—a clear violation of medical ethics.

Youseff was also subjected to sexual humiliations including forced nakedness and being forced to watch pornography. He also described an incident where a naked woman entered the interrogation room and smeared what he believed to be menstrual blood on him.

At one point, Youseff asked to speak with a psychologist because of sadness from being separated from his family. In subsequent interrogations, this information was exploited. He was threatened with staying in Guantanamo the rest of his life. Youseff believed the psychologist shared information with his interrogators. Again, a clear violation of medical ethics.

Youseff was released in Nov. 2003 after signing a false statement that he fought for the Taliban. He explained that he agreed to sign because "I was already under so much pressure." He was released without any charges brought against him as were other detainees who signed confessions. He was chained to the floor of an airplane, and returned to his home country.

Since his release he has continued to suffer from significant physical and psychological symptoms. He has persistent wrist pain. He continues to experience great feelings of sadness, and symptoms of post traumatic stress including nightmares, recurrent intrusive memories, avoiding anything that reminds him of his imprisonment. He becomes extremely anxious if he sees individuals dressed in orange, reminding him of his prison uniform, or if he sees police. He describes shortness of breath and heart problems, likely manifestations of anxiety. He has had difficult functioning since his release and has not found steady employment.

Physical examination revealed scars consistent with his report of undergoing wrist surgery following his release, and a scar on the back of his wrist consistent with handcuffing. He had tenderness in the muscles of his right wrist. His nose was slightly deviated to the left, though he acknowledged uncertainty about the etiology of this. A bone scan showed increased focal activity of both shoulders consistent with degenerative arthritis.

In sum, the available evidence provides strong support for the validity of Youseff's reports of abusive treatment while in US custody. In turn, this abusive treatment appears to have resulted in lasting physical and psychological symptoms that far exceed the mild level of distress Youseff reported experiencing prior to his arrest and detention by the United States.

AMIR (FORMER ABU GHRAIB DETAINEE)

Another individual I evaluated with Dr. Leanh Nguyen, a psychologist with the Bellevue/NYU Program for Survivors of Torture, is a former Abu Ghraib detainee identified in the report as Amir. He is in his late twenties and grew up in a Middle Eastern country. He was a salesman before being arrested by US forces in August 2003 in Iraq.

After his arrest, he was brought to another location where, while shackled, he was forced to stand naked for at least five hours. When the detainees asked the soldiers for permission to sit down, they were told, "Now, we will make you dance." The soldiers played "a very frightening voice" loudly over a stereo and forced the detainees to run around in a narrow room. This forced running continued for the next three days. The detainees were denied rest or sleep.

During this time, Amir's left foot was injured: "I noticed my blood everywhere." Nonetheless, he was forced to continue running. He described that he leaned against a stretcher, and reported his foot injury to the soldiers. One of the soldiers raised the stretcher sharply and he was thrown against a wall, hitting his head and losing consciousness. After regaining consciousness, Amir recalled that an interpreter hit him on his nose with a plastic water bottle, causing it to bleed. Amir believed that his nose was broken. Subsequently, he was forced to stand and was questioned along with the other detainees. After this incident Amir noted marked difficulty walking, and there was swelling in his knees and foot. He recalled that forced running and sitting on knees continued for about ten days.

Amir was then taken to another location. In the course of being transferred, plastic handcuffs placed on him were tightened to the point of causing his hands to swell and turn blue. Amir was held at this facility for twenty-seven days in a small dark room, where he was fed only twice daily and had to use a bucket as a toilet. He added, "You make your toilet in this bucket and you eat right next to it." During one of the many interrogation sessions, interrogators pushed his head against the wall. He recalled the soldiers humiliated him for having swollen knees. In one interrogation, while blindfolded and with his hands bound behind his back, he was forced to bend over and "walk zig zag and sometimes pushed into the wall."

In September 2003, Amir was taken to Abu Ghraib prison. Except for abuses he experienced on arrival, Amir recalled that he was generally treated well during his first month at Abu Ghraib. The food was better than before, and he was allowed to help soldiers distribute food to other detainees. However, he remembered that his situation changed when a new group of soldiers arrived at Abu Ghraib. He recalled that a soldier mistakenly suspected him of throwing a piece of food to a prisoner in another cell. The soldier yelled at him, "Bullshit, fuck you, fuck you." Amir recounted, "I can never forget these words because I knew he was insulting me." He was denied food that day, and that night soldiers took him to another room, restrained one of his hands to the wall, and put a bag over his head. A soldier lit a cigar and blew smoke into the bag over Amir's head. Amir recalled having a gun run up his body, poking at him, and pressed against his face. He was then taken back to his regular cell and told to sleep but, after fifteen minutes, the soldier returned screaming at him, took him back to the other cell, and tied him to the wall. Over the next two days the procedure was repeated four to five times. Amir described being deprived of sleep because the soldiers would hit a barrel or the doors of a cell with a hammer. "Because of this we could never sleep. Even if they permit you to sleep you could not because of this."

During the course of detention, Amir experienced several other abuses. On one occasion, Amir was playing with a broken toothbrush while sitting in front of his cell. When the soldiers saw this, they confiscated the broken tooth brush and accused him of manufacturing a dangerous weapon. They told him to take off his clothes. Amir recalled that he pleaded that his religion forbids nakedness. He was nevertheless restrained naked to the bars of his cell's door for two to three hours. He was then returned to his cell naked and without a blanket. The soldiers would come to his cell and humiliate him because of his nakedness.

Amir recounted remaining naked and being forced to pray in that condition. During that time, he recalled that a soldier came to his cell and started shouting. Amir was praying, so he did not answer. The soldier entered the cell, and pushed Amir's head to

the floor. He was then suspended with his arms up and behind his back for several hours, with only his toes touching the ground. During this time, Amir also heard increasingly high-pitched screaming from, in his words, “others who were tortured. The screaming was getting higher and higher.”

Subsequently, Amir was taken to a small foul-smelling room and was forced to lay face down in urine and feces. He noted, “You can’t even breathe because of that smell . . . [The soldier] pushed me to lie down. They brought a loudspeaker and started shouting in my ear. I thought my head would explode.” Amir subsequently described being sodomized with a broomstick that was forcibly inserted into his anus. He was pulled by a leather dog leash and was ordered to “howl like dogs do.” When he refused to do so he was repeatedly hit and kicked on his back and side. Amir felt a hot liquid on his back and guessed that someone was urinating on him. At this point, he was bleeding from his feet and shoulders, and the urine exacerbated the pain from these wounds.

He received more kicks on his left side and in the groin, and one of the men stepped on his genitals, causing him to faint. Amir subsequently woke up to cold water being poured on his head. He recalled hurting all over his body, particularly on the left lateral side of his chest, his right middle finger, and his groin and genitals. He noticed that his genitals were swollen and had wounds.

When asked about his internal responses to this episode of abuse, Amir described, “My soul was flying away. Like my body was not there. I started to think about my family . . . When I woke up [from the beating], I felt like I was not of this life. But my body was there, the pains in my body were there.”

Following this episode, Amir was kept naked in his cell for about four days. During that period, representatives of the International Committee of the Red Cross (ICRC) visited him and he told them about his mistreatment. The ICRC personnel provided him with clothing and blankets, which were confiscated after they left. Amir noted, “After four days, they gave me back my clothes and blankets and I went back to normal prison routine. By normal I mean they stopped hitting and torturing me.” Amir reported that the soldiers started calling him “Tarzan.” That nickname was written on a piece of paper and pasted on his cell door for six days. Explained Amir, “They called me this, because I had the toothbrush in my hand and I was naked like Tarzan, who held a knife and was naked. The interpreter explained this to me in detail.”

When asked “Did any doctor help you with your injuries?,” Amir uncharacteristically interrupted the interviewer and cried out, “Did I need to ask for help? I was there naked and bleeding. They were supposed to help. . . . These were not real doctors. They had no compassion. They were not there to practice medicine but to make war.”

Amir remained in that cell, alone, for another two months and then was transferred first to the communal tents at Abu Ghraib, and then to Bucca prison. In November 2004 he was released without charge.

In addition to the abusive treatment Amir reported directly experiencing, he also reported witnessing other prisoners being tortured and humiliated. Once, he saw naked prisoners being forced into a pile that formed a human pyramid. On another occasion, he was forced to watch two prisoners appearing to enact anal intercourse. Amir stated, “[The prisoners] were begging ‘This is a sin against our religion, please show mercy.’ The soldiers were pushing them into each other, and these guys were trying to [push] away, and this [lasted] more than half an hour and this was in front of our eyes.”

Amir reported feeling extremely weak, losing a great deal of weight, and experiencing severe headaches during his detention. While the headaches have improved, they persistently occur approximately once every one to two weeks. The headaches can be induced by feelings of nervousness, hunger, or anger; are often associated with vomiting and sensitivity to light; and can last from one hour to several hours or even an entire day. Amir also experiences periods of dizziness since his detention.

After being sodomized, Amir described having rectal bleeding and painful bowel movements that lasted approximately two weeks. The injuries to his genitals caused him chronic penile pain (lasting more than two months); blood in the urine (for about two weeks); and significant scrotal pain that gradually improved. He continues to have chronic discomfort in his left testicle, including during sexual intercourse.

Following the beatings, Amir described having pain all over his body. He continues to experience pain in his back and knees (particularly when walking) and discomfort in his right middle finger and his left big toe while walking. Moreover, since the trauma to his nose while in prison, Amir has had difficulty breathing. He continues to experience discomfort when sleeping on his left side, which worsens when he takes a deep breath.

Amir described experiencing palpitations (irregular heartbeats) multiple times a day, which he attributed to his memories of abuse. "These are the memories I can never forget . . . I want to forget, but it is impossible."

Many of the beatings Amir described would likely have resulted in bruises and soft tissue injuries that would not leave lasting physical marks. However, his physical symptoms and findings on physical examination strongly support Amir's reports of torture and mistreatment. Physical examination revealed a slightly curved and depressed scar on the left lower side of the nose, a slight bony prominence on the top left side of his nasal ridge, and a faint crackling sound on palpation at the tip of the nose. Several scars noted on his head are consistent with the kicks or other blunt trauma injuries he sustained during detention. Further, several scars were noted on his hands. Thickening of skin and prominent linear scars on the knees is consistent with Amir's reports. The two-centimeter raised hypo-pigmented (i.e., lighter than the surrounding skin), slightly angled, fibrotic band at the base of his left big toe is highly consistent with a scar resulting from a significant laceration as Amir described.

Musculoskeletal examination was significant for some slight tenderness over his scapular regions bilaterally, and tenderness over the area of the left lateral sixth rib with a slight prominence noted on palpation. The genital examination showed there was tenderness to palpation of the left testicle and a fibrous band between the base of the head of the penis and the shaft of the penis that Amir reported did not exist before. This is highly consistent with the events Amir described, including a traumatic injury and subsequent scarring process. Examination of the peri-anal area showed signs of rectal tearing that are highly consistent with his report of having been sodomized with a broomstick. The continued scrotal discomfort that he described is likely as a result of the injuries to this area that he reported sustaining.

Chronic headaches and dizziness are common among torture survivors who have experienced head trauma. The headaches and dizziness that Amir described, which he did not have prior to his imprisonment, are likely to be a result of the head trauma. Moreover, his continued psychological symptoms and distress likely contribute to these headaches as well.

Bone scan findings are consistent with a history of trauma to his ribs. Further, accumulation of the nuclear materials in both feet and ankles are consistent with a history of trauma to these areas.

Prior to his arrest, Amir described himself as a “calm and gentle person”, who was “good” to his family, and “smooth” and “patient” with everyone. In contrast, he described feeling that his family has been shattered and that much calamity had fallen on them because of him, and he spoke at length about feeling helpless to protect or provide for his family.

Following his release, Amir found himself constantly being “nervous” and “on edge”. He described a high level of stress caused by bombings, nightly raids, uncertainty about personal safety, frequent funerals of neighbors and acquaintances due to the war, and ongoing sadness about the losses that his family had sustained. Moreover, as a result of war conditions, Amir was unemployed at the time of evaluation. Nevertheless, Amir emphasized that his post-prison, war-related stressors are not the primary reason for his emotional “disturbances.” He stated, “No sorrow can be compared to my torture experience in jail. That is the top reason for my sadness. I cannot forget it.”

Amir’s reported symptoms and behaviors conform to all three clusters of PTSD symptoms including intrusive recollections of the trauma, hyperarousal, and avoidance. These symptoms are directly traceable to the traumatic experience that he reported. Amir described suffering from flashbacks and nightmares about his imprisonment. His days are preoccupied with images and thoughts of his imprisonment. He added, “It is like in my head I have never left Abu Ghraib.” He experiences fear and outrage, and exhibits physiological reactivity (i.e., startle response, throat constriction, chest pain, heart palpitations) when exposed to cues that are reminiscent of the trauma, such as the sight of US soldiers or the recollection of his torture.

Amir reported numerous symptoms of hyperarousal including suffering from severely disturbed sleep, often sleeping approximately two hours a night; moodiness; outbursts of anger; and exaggerated startled response.. Furthermore, he described symptoms of avoidance and emotional numbing, including avoiding open space, people, and social activities; and feeling flat or constricted in his emotions. He also confirmed feeling isolated, and detached or disinterested in forming social relations after his release from prison.

Amir described feeling helpless and having a “dark” sense of the future. Moreover, he articulated a sense of wounded pride and stolen honor. He explained that the dissemination of photographs from Abu Ghraib on the Internet had exposed his humiliation to the world. He is concerned that this public knowledge has ensured that his children will suffer the blame and dishonor of his reputation as a former detainee and will thus be at risk for a life of shame.

Amir disclosed that he constantly harbors suicidal ideation, although he adheres to Islam’s teachings which prohibit suicide. While in prison he tried to kill himself by banging his head against a hard surface. He reported frequent thoughts of revenge and homicidal fantasies.

The symptoms of sexual dysfunction are consistent with a previous history of sexual violation. He reported having trouble being naked in front of his wife. Flashbacks of his torture, especially the sexual aspects, often intruded during sex with his wife. In such instances, he would then “lose all strength.” Along with erectile dysfunction, he also reported low sexual drive and minimal interest in sex. Amir specifically described triggers,

context, and time frame that connect the sexual dysfunction to the traumatic violation of his experiences at Abu Ghraib. The impairment is likely linked to post-traumatic re-experiencing of the sexual violation.

Amir demonstrated historical, physical, and psychological evidence strongly supporting his allegations of torture. He provided substantial detail regarding many components of his abuse. He was forthcoming about what he does and does not recall. The manner in which Amir described his detention experience, both in content and in style, as well as the clinical findings lead us to conclude with high confidence that he is credible. Amir continues to suffer from physical and psychological symptoms since his release from Abu Ghraib, and described subsequent marked impairments in his social, sexual, and emotional functioning.

CONCLUSION AND RECOMMENDATIONS

In summary, the evaluations of both of these men revealed clear historical, physical, psychological, and radiographic evidence corroborating their allegations of torture and abuse. Both continues to suffer from severe symptoms. In fact all 11 men evaluated for this study had findings consistent with their reports of torture and abuse.

As a physician and scientist who has spent much of his professional career evaluating and caring for victims of torture and abuse, I want to clearly state that torture and inhuman interrogation techniques are cruel, ineffective and can have devastating health consequences, as evidence by the two former detainees I described. As a health professional, these abuses and the harm they cause deeply offend medical ethics and values. As an American, they offend the traditions and principles we have long shared and cherished as a nation, including a ban on torture and cruel, inhuman or degrading treatment or punishment.

I am very concerned that when we as a country condone such methods, we are putting our soldiers and others U.S. citizens living around the world at risk. Furthermore, practicing or condoning torture by our country in any way runs the risk of increasing what is already a world wide public health epidemic of torture-documented to occur in more than 100 countries. Torture is frequently invoked in the name of national security, whether the victim is a Tibetan monk calling for independence or an African student advocate protesting for democracy. While torture is not effective in eliciting accurate information, it is effective in undermining community, trust and safety. Any condoning of torture or mistreatment by our country, puts innocent civilians around the world promoting democracy and freedom under despot regimes in harms way.

The United States must commit itself to repairing the damage done and restore our credibility. In order for this to occur, the following needs to happen:

1. The executive branch must repudiate all forms of torture and cruel, inhuman or degrading treatment. Uniform standards of conduct should be established prohibiting any military, intelligence or other officials, including contract personnel, from engaging in such acts. Congress should enact laws prohibiting and establishing criminal liability for their violation.

2. There must be a complete and independent investigation of what happened in Guantanamo, Abu Ghraib and other places where terrorist suspects were detained.

Individuals responsible for abuse-both in the field, including health professionals, and up the chain of command must be held accountable.

3. Our government owes formal apology to detainees who were subjected to torture and ill treatment as part of military and intelligence operations since fall 2001 in Afghanistan, Iraq, Guantanamo Bay, Cuba and Elsewhere. Furthermore, the government should establish a fair process for compensation and victim assistance, including access to rehabilitation and re-integration services, for individuals subjected to torture or ill-treatment in US custody.

4. All places of detention operated by the United States should be subject to monitoring by international bodies that investigate detainee treatment and are capable of reporting findings to the public and government, including the UN Special Rapporteur on Torture, the UN Committee Against Torture, and the International Committee of the Red Cross. Furthermore, congressional and executive branch oversight of US intelligence activities relevant to detainee treatment and interrogation should be immediately strengthened and improved.

5. The US Department of Justice should release all legal opinions and other memoranda concerning standards regarding interrogation and detention policy and practices.

In conclusion, we must ensure that torture and mistreatment, no matter what you call it, are neither condoned nor take place under our great country's watch. Though perhaps invoked, misguidedly in the name of national security, the abuses committed by the United States have undermined our integrity and made the world a much more dangerous place. We must take responsibility for what has happened, and see that it never happens again.

Thank you.

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The challenge of hunger strikes and the risk of medical complicity in abuse and torture in U.S. detention facilities.

Hunger strikes have posed a major challenge to health professionals charged with detainee care in U.S. detention facilities. According to press reports, in 2005, at least 131 detainees staged hunger strikes, and in 2006, the number was at least 86. These reports represent the low end, as accurate data about the number of hunger strikes are hard to come by.

The response to these hunger strikes has been concerning. The press has reported force feedings that were undertaken early on in the strike where there was likely no legitimate medical justification in an effort to “break the strike,” a significant violation of medical ethics and basic human rights. Prolonged force-feeding of individual strikers continues to this day. Forced feeding may involve physically restraining the detainee in a chair and passing a nasogastric tube through the nose and esophagus into the stomach. This is an uncomfortable procedure in the case of informed consent. It is potentially psychologically traumatizing when done against the will of the patient.

The most widely accepted medical ethical guidelines on hunger strikes are the World Medical Associations Declaration, which has been adopted by the American Medical Association. According to that guideline, force-feeding of a competent and informed patient is never justifiable, as autonomy of the patient to consent to an invasive medical procedure trumps the duty to preserve life at all costs.

The issue of possible medical complicity in human rights violations of detainees is deeply disturbing and provocative. For anyone familiar with the professionalism of military medicine, it seems unlikely if not downright impossible that U.S. military health professionals would ever engage in violations of detainees’ rights, directly or indirectly. In discussing the problems surrounding the management of hunger strikes in U.S. detention facilities such as those at Guantanamo, I hope to shed some light on how good doctors come to do bad things.

First, while doctors should be more ethical than most people, the fact is that they are as vulnerable as anyone else to rationale for abandoning professional ethics. This is particularly true in settings where a competing loyalty, such as loyalty to the security or military mission comes into conflict with medical professional ethics and standards. This phenomenon is known as dual loyalty.

Doctors are also vulnerable to the rationalization of “exceptionalism,” or the notion that the current challenges in this war make traditional medical ethics “quaint,” or no longer relevant or applicable. In fact, medical ethics in the military tradition were developed exactly to prevent this kind of abuse. Possible and imminent threat, potentially catastrophic, is not new to the theatre of war or the tradition of military medicine, and such threats do not change the fundamental responsibility of the physician to respect the autonomy and human dignity of his or her patient.

While we can certainly discuss the conflict between the duty to preserve life versus the duty of honor an informed and competent refusal of an invasive medical procedure,

even when death may result, I'd like to broaden the discussion to address the context of the hunger strike.

As a former prison doctor and medical director, I am often asked what parallels exist in correctional medicine for the management of hunger strikers. While there are many parallels, it may be more important here to highlight fundamental differences.

In U.S. jails and prisons, inmates have access to many alternative means of addressing legitimate complaints, such as grievance procedures, access to their lawyers, family, the courts, and the press. In addition, continuous outside review of conditions in facilities by the public, advocates, legislative bodies and most importantly the courts lead to facilities that are less likely to violate constitutionally guaranteed rights such as habeas corpus and violations of cruel and unusual punishments.

Detention settings that do not respect human dignity raise the risk of hunger strikes and complicate their successful resolution.

The lack of such protections and alternative means of resolution of legitimate disputes in U.S. detention facilities such as Guantanamo is the faulty foundation that actually sets the stage for 1) more hunger strikes and 2) hunger strikes that are clinically more difficult to resolve without the use of force. In other words, it is the very structure and flawed design of the facilities that set the stage for human rights violations and place health professionals at high risk of facing dual loyalty conflicts that can result in medical complicity in abuse or torture.

There are other barriers to the successful resolution of hunger strikes in these settings that result from both the context and from flawed policy. They include:

1. FAILURE TO RESPECT THE PATIENT'S AUTONOMY TO MAKE AN INFORMED REFUSAL.

This is the fundamental flaw of the hunger strike protocols employed by DoD. They require health professionals to engage in an invasive medical procedure in the face of an informed refusal of a competent patient. This is in direct conflict with widely accepted medical ethics as articulated by the World Medical Association and adopted by the American Medical Association.

[Consent: exam or assault?]

2. LACK OF DOCTOR-PATIENT TRUST AND CLINICAL AUTONOMY.

It is virtually impossible for a physician to perform his or her duty in the absence of trust between the doctor and the patient. In detention settings this challenge is great under the best of circumstances. The extent to which the doctor can gain the trust of the patient is directly proportional to the level of autonomy the physician has from the non-medical chain of command. Physicians seen by the patients as subordinate to the security staff are less likely to be trusted. Physicians who act against the patient's interests will not be trusted at all.

Press reports have described simultaneous forced feeding of groups of hunger strikers in order to "break the strike." This is a complete violation of medical autonomy, consent issues aside. Care must be individualized and be motivated by the interests of the patient,

and directed by a clinician. Use of physicians or other health personnel to force-feed detainees in order to maintain order is asking health professionals to participate in an assault on their patients and irreparably damages the foundation of trust.

3. LACK INDEPENDENT REVIEW AND CARE OPTIONS OUTSIDE THE CHAIN OF COMMAND.

The lack of outside consultation and review by clinicians removed from the chain of command further complicates the clinician's task. This robs the clinician of key tools that can be used to develop trust and provide non-confrontational alternatives to resolution of the strike. It also robs the process of legitimacy and integrity.

SUMMARY

Forced feeding without consent is simply one example of the risk of medical complicity in torture. In settings where basic human rights and dignity are not protected, it is difficult for doctors, caring professionals who are in the human dignity business, to do their job in a manner that is consistent with professional values and ethics.

Current detainee policies and practices are problematic because they place physicians and other health professionals in high-risk settings where they often must choose between respecting the rights of their patients and loyalty to command. In this environment, even the best physicians are at risk of compromising their ethics and allowing abuse and even torture to occur. In some cases, health professionals themselves may even play an active role in patient abuse and torture.

While the hunger strike policies and procedures of the DoD could be greatly improved, in facilities where basic human rights are not respected, doctors, no matter how decent, cannot resolve the problem of hunger strikes by clinical interventions alone. Without respect for basic human rights, the ethical practice of medicine is impossible.



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