



**AIDING TORTURE:
Health Professionals'
Ethics and Human Rights Violations
Revealed in the May 2004
CIA Inspector General's Report**

A Report by
Physicians for Human Rights
August 2009

PHYSICIANS FOR HUMAN RIGHTS

PHR was founded in 1986 on the idea that health professionals, with their specialized skills, ethical commitments, and credible voices, are uniquely positioned to investigate the health consequences of human rights violations and work to stop them.

Since 2005, PHR has documented the systematic use of psychological and physical torture by US personnel against detainees held at Guantánamo Bay, Abu Ghraib, Bagram air-base, and elsewhere in its groundbreaking reports *Break Them Down*, *Leave No Marks*, and *Broken Laws, Broken Lives*.

PHR is a non-profit, non-sectarian organization funded through private foundations and by individual donors. Membership is open to all, not only health professionals. PHR shared the 1997 Nobel Peace Prize.

2 Arrow Street, Suite 301
Cambridge, MA 02138 USA
Tel: +1.617.301.4200
Fax: +1.617.301.4250

<http://physiciansforhumanrights.org>

Washington DC Office:
1156 15th St. NW, Suite 1001
Washington, DC 20005 USA
Tel: +1.202.728.5335
Fax: +1.202.728.3053

© 2009, Physicians for Human Rights

AUTHORS

Scott Allen, MD

Associate Professor of Medicine,
Alpert School of Medicine
Co-Director, Center for Prisoner Health and Human Rights,
Brown University
Medical Advisor, Physicians for Human Rights

Allen Keller, MD

Associate Professor of Medicine, NYU School of Medicine
Director, Bellevue/NYU Program for Survivors of Torture
Advisory Board Member, Physicians for Human Rights

Steven Reisner, PhD

Adjunct Professor of Counseling and Clinical Psychology,
Teachers College, Columbia University
Clinical Assistant Professor, NYU School of Medicine
Advisor on Psychological Ethics,
Physicians for Human Rights

Vincent Iacopino, MD, PhD

Senior Medical Advisor, Physicians for Human Rights
Adjunct Professor of Medicine,
University of Minnesota Medical School
Senior Research Fellow, Human Rights Center,
University of California, Berkeley

Introduction

The version of the 2004 CIA Inspector General's report released on August 24, 2009 provides greater detail on the central role that health professionals played in the CIA's torture program and reveals a level of ethical misconduct that had not previously come to light.

The report confirms that the CIA inflicted torture on detainees interrogated while in US custody as part of the agency's counterterrorism activities and exposes additional interrogation techniques that had not yet been reported. It also demonstrates that health professionals were involved at every stage in the development, implementation and legitimization of this torture program.

The doctors and psychologists who laid the foundation upon which attorneys rationalized an illegal program of torture also actively participated in abusive and illegal interrogations, thus betraying the ethical standards of their professions by contributing to physical and mental suffering and anguish. The very premise of health professional involvement in abusive interrogations — that they have a role in safeguarding detainees — is an unconscionable affront to the profession of medicine.

The Inspector General's report also reveals that medical professionals were directed to meticulously monitor the waterboarding of detainees to try to improve the technique's effectiveness, essentially using the detainees as human subjects, a practice that approaches unlawful experimentation.

Physicians for Human Rights (PHR) has prepared the following analysis of the Inspector General's report, building on PHR's 2007 report *Leave No Marks*, which assessed interrogation techniques reported up to that time, which have now been confirmed by the Inspector General's report. This paper provides an introductory summary of techniques newly described in the Inspector General's report and then offers a more detailed medical analysis of those techniques. The paper then reviews the various ways health professionals were complicit in enabling the torture regime.

Summary of Newly Detailed Techniques

The Inspector General's report describes several forms of abuse not previously reported that CIA interrogators and contractors implemented, and that from a medical and legal perspective constitute torture. These include:

- Mock executions and threatening detainees by brandishing handguns and power drills;
- Threatening the detainee with harm to his family members including sexual assault of female family members, and murder of detainee's children; and
- Physical abuse including the application of pressure to the arteries on the sides of a detainee's neck resulting in near loss of consciousness, and tackling or hard take-downs.

These methods have significant harmful physical and mental health consequences.

The report provides new details about previously reported forms of abuse referred to as "enhanced interrogation techniques". The harmful health consequences of these forms of torture and abuse have previously been described by PHR, including in the reports *Break Them Down, Leave No Marks* and *Broken Laws, Broken Lives*.¹

The Inspector General's report clearly questions the efficacy, ethics and legality of these as well as the previously mentioned "enhanced interrogation techniques". The report also confirms the theory of a "slippery slope" in interrogation settings, namely that torture by its very nature escalates in the severity and frequency of its use beyond the approved techniques.

Medical Analysis of the Interrogation Techniques Described in the Inspector General's Report

The adverse physical and mental health effects of stripping (forced nudity), isolation, white noise or loud music, continuous light or darkness (sensory deprivation), temperature manipulation, stress positions, sleep deprivation, attention slap, abdominal slap, stress positions and waterboarding have been previously described in the Physicians for Human Rights and Human Rights First report *Leave No Marks*. The following medical analysis focuses on techniques not previously reviewed by PHR.

As with the techniques previously analyzed, it is important to understand two key points. First, while the techniques are evaluated individually, these techniques were designed to be used in combination in a way that enhanced pain and stress.

Second, to comprehend the severity of the effects of these techniques, it is essential to consider the context of their use. In terms of both long and short term psychological effect, there is no meaningful equivalence between waterboarding when used as part of survival training of service men who have volunteered and consented to the procedure and who know that they are in an environment where they trust the mock interrogator to protect their safety and may stop the procedure at any time, and waterboarding of a high value detainee in a black site where the detainee is in actual fear for his life and safety. As the Inspector General's report indicates:

*"One of the psychologist/interrogators acknowledged that the Agency's use of the [waterboarding] technique differed from that used in SERE training and explained that the Agency's technique is different because it is 'for real' and is more poignant and convincing."*²

¹ *Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and Its Impact*. 2008. Available at: http://brokenlives.info/?page_id=69. Also see: *Break Them Down: Systematic Use of Psychological Torture by US Forces*. Physicians for Human Rights. Available at: <http://physiciansforhumanrights.org/library/report-2005-may.html>

² Inspector General's report p. 37.

Analysis of New Approved Techniques Revealed in Inspector General's Report

The additional approved techniques listed in the Inspector General's report and not previously analyzed by PHR include shaving, hooding, restricted diet, prolonged diapering, "walling" and confinement boxes.

As with the previously reviewed techniques, while these techniques can have harmful physical as well as mental health effects, their chief objective is to produce psychological impact, and their chief risk is prolonged mental pain and suffering.

1. Forced shaving

Forced shaving of the head and beard was alleged by two of the fourteen detainees interviewed by the ICRC for its 2007 report.

*Mr. Ramzi Bin-al-Shib alleged that, in his eighth place of detention, first his head was shaved and then some days later his beard was also shaved off. He was particularly distressed by the fact that the people who shaved him allegedly deliberately left some spots and spaces in order to make him look and feel particularly undignified and abused.*³

In 2007, PHR physicians examined a former US detainee, who reported:

*"When they finished hitting me... they shaved my hair. The only hair I had was in the middle. This was only to humiliate me."*⁴

Medical Analysis: Forced shaving obviously carries little risk of physical harm, and is chiefly designed to inflict psychological harm by means of humiliation, both personal and religious. Forced shaving was part of a campaign to sever the sense of self derived from religious belief, and was often accompanied by forced removal of religious articles.

In addition to the violation of cultural and religious taboos, forced shaving constitutes an intrusion into the personal space and bodily integrity of the person, infringing on autonomy and self-control. The combined effects of this type of treatment in combination with other techniques have been associated with long-lasting psychological injury such as posttraumatic stress disorder, anxiety and depression.

2. Hooding

Detainees were blindfolded or hooded to instill in them a sense of fear, disorientation and dependency on their captors.

According to the February 2004 report of the International Committee of the Red Cross (ICRC) on treatment of detainees in Iraq:

*Hooding [was] used to prevent people from seeing and to disorient them, and also to prevent them from breathing freely. One, or sometimes two bags, sometimes with an elastic blindfold over the eyes which, when slipped down, further impeded proper breathing. Hooding was sometimes used in conjunction with beatings thus increasing anxiety as to when blows would come. The practice of hooding also allowed the interrogators to remain anonymous and thus to act with impunity. Hooding could last for periods from a few hours to up to 2 to 4 consecutive days, during which hoods were lifted only for drinking, eating or going to the toilets.*⁵

PHR reported in *Broken Laws, Broken Lives* that according to former detainees medically evaluated by PHR, hooding was used both during transportation and during interrogation.

Medical Analysis: When not used in transport, hooding is a form of sensory deprivation aimed at causing dislocation and confusion. Research shows that prolonged sensory deprivation can result in depression, depersonalization and psychosis. According to the ICRC report, hooding, and other observed sensory deprivation techniques resulted in

*"signs of concentration difficulties, memory problems, verbal expression difficulties, incoherent speech, acute anxiety reactions, abnormal behavior and suicidal tendencies."*⁶

3. Dietary Manipulation

Detainees were deprived of solid food for periods ranging from days to months. Mr. Abu Zubaydah alleged that for a period of two to three weeks during his initial period of interrogation, he was kept sitting on a chair constantly and only provided with liquid Ensure (a nutrient formula) and water. Mr. Bin-al-Shib reported that he went three to four weeks without solid food, and was only provided with Ensure and water. In addition, six other high-value detainees reported being deprived of solid food for periods ranging from days to weeks.⁷

Medical Analysis: While physical risks of a liquid diet are minimal as long as appropriate calories and nutrients are provided, the intent of dietary manipulation is to inflict psychological distress by infringing on the detainee's sense of autonomy and self control and increasing discomfort and a sense of helplessness and dependency. While the risk of death or debilitation may be minimal, the effects on concentration and mood may be substantial.

4. Prolonged Diapering

Detainees were placed in diapers and denied access to a toilet for prolonged periods of time. According to the ICRC Report,

³ ICRC Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody. International Committee of the Red Cross. February 2007. Available at <http://www.nybooks.com/icrc-report.pdf>.

⁴ *Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and Its Impact*. 2008. Available at: http://brokenlives.info/?page_id=69. The former detainee's history was deemed credible by examining physicians. He suffers from symptoms consistent with posttraumatic stress disorder.

⁵ ICRC Report.

⁶ ICRC Report.

⁷ ICRC Report.

high value detainees in CIA custody were placed in diapers for prolonged periods for transport.

The detainee would be made to wear a diaper and dressed in a tracksuit... The journey times obviously varied considerably and ranged from one hour to over twenty-four to thirty hours. The detainee was not allowed to go to the toilet and if necessary was obliged to urinate or defecate in the diaper.

The ICRC report states that one of the detainees, Mr. Bin Attash, was compelled to wear a diaper for a prolonged period: *[H]e commented that on several occasions the diaper was not replaced so he had to urinate and defecate on himself while shackled in the prolonged stress standing position. Indeed, in addition to Mr. Bin Attash, three other detainees specified that they had to defecate and urinate on themselves and remain standing in their own body fluids.*⁸

Medical Analysis: Prolonged diapering especially when combined with leaving the subject in a diaper soiled with urine and feces can result in both physical and psychological harm. Prolonged exposure of the skin can result in skin infection, skin breakdown and ulceration and urinary tract infections. In addition, the placement of a normally continent adult in a diaper will likely lead to efforts by the adult to resist urination or defecation, which in turn will likely result in bowel cramping and bladder spasm.

Access to toilet is a universally recognized minimum standard for prisoners and detainees. In spite of the physical risks, the chief aim of this technique is to cause psychological stress through humiliation, induced dependency, loss of autonomy, and regression to an infantile state.⁹ Like all such techniques, especially when combined with others of the ‘DDD’ type (debility-dependency-dread), these are cumulative and lead to short and long-term debilitation. At Guantánamo, the standard operating procedures included requiring the detainee to ask the interrogator for toilet paper, food, and religious articles. Here, the torturers go even further, returning the detainee to pre-toilet-training levels. When combined with a liquid diet, the experiences of regression, humiliation, and dependency are magnified.

5. Walling

Six of the fourteen high-value detainees interviewed by the ICRC reported being placed in a neck collar or roll and then slammed against a wall. According to the CIA guidelines, slamming against a wall could be used twenty or thirty times consecutively.

During the walling technique, the detainee is pulled forward and then quickly and firmly pushed into a flexible false wall so

⁸ ICRC Report.

⁹ “The purpose of all coercive techniques is to induce psychological regression in the subject by bringing a superior outside force to bear on his will to resist. Regression is basically a loss of autonomy, a reversion to an earlier behavioral level. As the subject regresses, his learned personality traits fall away in reverse chronological order...” Human Resource Exploitation Manual, CIA, 1983

that his shoulder blades hit the wall. His head and neck are supported with a rolled towel to prevent whiplash.¹⁰

Although the guidelines require that the wall be a specially constructed flexible one, some detainees alleged that they were also slammed against concrete wall using the collar during transport.¹¹

Mr. Bin Attash alleged that during interrogation in Afghanistan:

“on a daily basis during the first two weeks a collar was looped around my neck and then used to slam me against the walls of the interrogation room.”

Medical Analysis: Walling results in blunt trauma and acceleration/deceleration type injuries. Blunt trauma can result in bruises and bleeding from ruptured blood vessels. Studies have observed persistence of musculoskeletal pain cause by blunt trauma even a decade after the trauma has occurred. In rare cases, repeated beating can cause damage to muscle tissue and muscle breakdown resulting in release of muscle enzymes resulting in a life-threatening condition called *rhabdomyolysis*. In addition, walling can expose the subject to risk of whiplash type injury to the neck and spine.¹²

Psychological stress, which is the primary aim of the procedure, is achieved by use of surprise, generating a startle response, an experience of shock, loss of control and helplessness. Also, rage is engendered which turns to further humiliation, insofar as the detainee cannot fight back.

6. Confinement in a Box

Confinement in a box is a rather extreme version of a stress position with the added potential for claustrophobia.

According to the ICRC report, Abu Zubaydah alleged that in Afghanistan in 2002 he was held in boxes designed to constrain his movement. Mr. Zubaydah stated:

“As it was not high enough even to sit upright, I had to crouch down. It was very difficult because of my wounds. The stress on my legs held in this position meant that my wounds both in the leg and the stomach became very painful.”

He went on to say that a cover was placed over the boxes while he was inside making it hot and difficult to breathe.

Medical Analysis: Confinement in a box is an extreme example of stress positions, with the added effect of decreased access to fresh air, temperature changes, light deprivation and isolation. Stress positions have been associated with permanent joint and ligamentous injury, and both acute and prolonged musculoskeletal pain. In addition, use of stress positions following blunt trauma carries the risk of deep vein thrombosis (clotting) and associated and potentially fatal pulmonary emboli. This is not a theoretical risk, as at least two detainees in

¹⁰ CIA guidelines as reproduced in Inspector General’s report, p. 15.

¹¹ ICRC Report.

¹² *Leave No Marks*.

US Custody in Afghanistan died of pulmonary emboli due to use of stress positions in interrogation settings.¹³

Confinement in a box was devised as a direct appropriation of Martin Seligman's research on "learned helplessness." In fact, on at least two occasions, Seligman presented his learned helplessness research to CIA contract interrogators referred to in the Inspector General's report. In Seligman's experiment, dogs were confined to boxes in which they discovered that familiar mechanisms of control would no longer have an effect in avoiding pain.

Like their canine counterparts, humans subjected to similar confinement develop psychomotor and cognitive responses that would be clinically diagnosed as depression and, in certain cases, PTSD. Such symptoms include apathy, helplessness, hopelessness, foreshortened sense of future, and a (in this case justified) lack of belief in their ability to affect their future prospects. In Seligman's experiments, these symptoms were severe and lasting, in that a change to an environment where the dogs could have an effect did not change the symptoms of learned helplessness.

Unapproved and Improvised Techniques

The Inspector General's Report contains numerous accounts of interrogation techniques that were not approved for use, including threats with a gun and power drill, threats of harm to loved ones, and choking and carotid artery pressure.

Threats of harm to the detainee or loved ones are reviewed in *Leave No Marks*. The risks of choking and carotid artery pressure should be self-evident. They include risk of choking death and stroke, as well as high risk of psychological trauma from a near-death experience. Near-death experiences are highly correlated with the risk of developing post traumatic stress disorder.

Role of Health Professionals in Torture

Health professionals played central roles in developing, implementing and providing justification for torture.

Health professionals in the Office of Medical Services and psychologist contractors¹⁴ engaged in designing and monitoring

harmful interrogation techniques.¹⁵ Such medical participation in torture is a clear violation of medical ethics. Furthermore, health professionals were complicit in selecting and then rationalizing these abusive methods whose safety and efficacy in eliciting accurate information have no valid basis in science. The severe physical and psychological pain and enduring harms associated with these techniques make it evident that they constitute torture and ill treatment. Monitoring of interrogation techniques by medical professionals to determine their effectiveness uses detainees as human subjects without their consent, and thus also approaches unlawful experimentation.¹⁶

According to CIA guidelines, health professionals including a psychologist and doctor were required to be present during the use of enhanced interrogation techniques.¹⁷ The required presence of health professionals did not make these methods safer, and in fact only served to sanitize their use and enable the abuse to escalate, thereby placing health professionals in the untenable position of calibrating harm rather than serving as protectors and healers as required by their ethical oath.

The report also documents the role of health professionals in participating in initial psychological and physical assessments of detainees in an intake process closely linked to the process of interrogation. By requirement, all interrogations were monitored in real-time by health professionals. Previous reports, including the ICRC report, document allegations that a medical device called a pulse oximeter (a device to measure oxygen saturation in a subject's blood) was placed on the finger of a

¹⁵ "Several months earlier, in late 2001, CIA had tasked an independent contractor psychologist, who had [redacted] experience in the US Air Forces' Survival, Evasion, Resistance, and Escape (SERE) training program, to research and write a paper on Al-Qa'ida's resistance to interrogation techniques. This psychologist collaborated with a Department of Defense (DoD) psychologist who had [redacted] SERE experience in the US Air Force and DoD to produce the paper "Recognizing and Developing Countermeasures to Al-Qa'ida's Resistance to Interrogation Techniques: A Resistance Training Perspective." Subsequently, the two psychologists developed a list of new and more aggressive EIT's [enhanced interrogation techniques] that they recommended for use in interrogations." Inspector General's Report p. 13. "CIA's OTS obtained data on the use of the proposed EIT's and their potential long-term psychological effects on detainees. OTS input was based in part on information solicited from a number of psychologist and knowledgeable academics in the area of psychopathology" and "OTS also solicited input from DoD/Joint Personnel Recovery Agency (JPRA) regarding techniques used in SERE training and any subsequent psychological effects on students." Inspector General's Report p. 14.

¹⁶ The Office of Medical Services guidelines for waterboarding state "A rigid guide to the medically approved use of the waterboard is not possible, as safety will depend on how the water is applied and the specific response each time it is used. The following general guidelines are based on very limited knowledge, drawn from very few subjects whose experience and response was quite varied." They add "NOTE: In order to best inform future medical judgments and recommendations, it is important that every application of the waterboard be thoroughly documented: how long each application (and the entire procedure) lasted, how much water was applied, if a seal was achieved, if the naso- or oropharynx was filled, what sort of volume was expelled, how long was the break between applications, and how the subject looked between each treatment."

¹⁷ "In 2004, when Daniel B. Levin, then the acting assistant attorney general in the counsel's office, sent a letter to the CIA reauthorizing waterboarding, he dictated the terms: "no more than two sessions of two hours each, per day, with both a doctor and a psychologist in attendance." Report Shows Tight CIA Control on Interrogations. Mark Mazzetti and Scott Shane. New York Times, August 26, 2009. Available at: http://www.nytimes.com/2009/08/26/us/26prison.html?_r=1&hpw

¹³ Allen S. Rich J. Bux R. Farbenblum B. Berns M. Rubenstein L. Deaths of Detainees in the Custody of US Forces in Iraq and Afghanistan from 2002 to 2005. *Medscape General Medicine*: 2006;8(4):46.

¹⁴ From the DoD's Joint Personnel Recovery Agency (JPRA) and SERE (Survival, Evasion, Resistance and Escape) Programs.

detainee to monitor the effectiveness of his respiration during waterboarding.¹⁸ In this way, medical professionals were used to calibrate physical and mental pain and suffering.

Not only were health professionals involved in designing and monitoring the CIA interrogation program, they also played an indirect but essential role in the legal justifications for the program prepared by the Office of Legal Counsel (OLC). The OLC was asked by the CIA whether certain techniques constituted torture under 18 USC §2340 by causing “severe physical or mental pain or suffering.” Since the OLC lawyers had no direct experience of the techniques, they necessarily relied instead on the judgment of health professionals. Yet, in a striking example of bootstrapping, they turned for advice about the pain caused by the techniques to the very health professionals who were implementing them.¹⁹

In essence, the lawyers were asked if the techniques constituted torture and they replied to the CIA that they only did so if the CIA Office of Medical Services (OMS) informed them that the techniques reached the defined standard of pain. The OMS health professionals obligingly passed on through CIA channels their opinion that the pain was not in fact severe

In an egregious example of this circular process, one OLC memo concludes that waterboarding is not torture because “however frightening the experience may be, OMS personnel have informed us that the waterboard technique is not physically painful.” Scores of similar references to OMS medical judgments about pain and the safeguarding effects of medical monitoring appear throughout the memos. Although OMS did express some concern about some techniques, those objections were limited. Without the cooperation of health professionals in making these assessments, the OLC memos could not have reached the conclusions they did and could not have so easily justified torture.

The intent of the CIA interrogation program was to cause severe psychological distress.²⁰ Despite citation of unnamed

¹⁸ ICRC report. Note that the use of a pulse oximeter, and the requirement that an emergency tracheostomy kit be kept ready is even more evidence that the procedure is intentionally harmful, risky and potentially lethal.

¹⁹ In certain cases the very same JPRA psychologists who designed the torture and implemented the techniques, and, who, as private contractors, profited from the operation, also provided the research that justified the techniques: “You have informed us that your on-site psychologists, who have extensive experience with the use of the waterboard in Navy training, have not encountered any significant long-term mental health consequences from its use. Your on-site psychologists have also indicated that JPRA has likewise not reported any significant mental health consequences from the use of the waterboard.”

²⁰ CIA Inspector General’s Report. Appendix F. “Captured terrorists turned over to the CIA for interrogation may be subjected to a wide range of legally sanctioned techniques, all of which are also used on US military personnel in SERE training programs. These are designed to psychologically ‘dislocate’ the detainee, maximize his feelings of vulnerability and helplessness, and reduce or eliminate his will to resist our efforts to obtain critical intelligence.” In addition, the sanction techniques include so-called “Standard measures” or those deemed to be without physical or substantial psychological pressure and so-called “Enhanced measures,” or those deemed to cause physical or psychological pressure beyond “Standard measures.” (p. 1). “In all instances, the goal of these techniques is psychological impact...” and are “designed to induce shock, surprise and/or humiliation.” (p. 2).

experts who reportedly concluded that these techniques were unlikely to cause significant harm, the notion that these abusive techniques can be used safely has no basis in medical science and is not supported by an extensive peer-reviewed literature.²¹ From a medical, scientific and common sense perspective the idea that such abusive and inhumane techniques can be safely deployed is unsupportable. The techniques authorized and deployed have long been documented to cause significant and long lasting psychological pain and suffering including post-traumatic stress disorder, anxiety and major depression.²² In fact, a recent study demonstrates that abusive techniques employed during captivity which emphasized psychological torture over physical injury, such as psychological manipulation, forms of deprivation, humiliation and stress positions, cause as much mental pain and traumatic stress as does torture designed to inflict physical injury.²³

The use of these abusive methods violates international human rights standards. The likely illegality of the program was known to the agency and debated within the agency. Those advocating for the use of abusive techniques such as waterboarding should have known that the US had prosecuted these same techniques as torture. Health professionals who were involved in its justification, design and implementation should have known that professional ethics prohibit health professionals from complicity in such harmful acts against prisoners or detainees. It is precisely to avoid such complicity that health professionals have recourse to professional codes of ethics, as well as international standards of medical conduct. Familiarity with these codes – not to mention basic human decency – should preclude such conduct, making clear to health professionals and government institutions both its essentially unethical nature and illegal status under international law.

Not only should interrogators be subject to an investigation of alleged criminal conduct. Health professionals who were involved in this program should be the subject to independent investigation for both criminal and unprofessional conduct. Professionals who have violated professional ethics or the law must be held accountable through criminal prosecution, loss of license and professional society membership, where appropriate.

²¹ See *Leave No Marks and Broken Laws, Broken Lives*. Although these reports were published in 2007 and 2008 respectively, they summarized scientific literature that was well established in 2001. In a bizarre justification for the safety of the techniques, the OLC report states, “You have also reviewed the relevant literature and found no empirical data on the effect of these techniques with the exception of sleep-deprivation.” OLC August 1, 2002, p. 6. Yet, there is a large body of research on the effects of these and similar techniques, much of it supported by the CIA. See for example *The Search for the Manchurian Candidate* (c) 1979 by John Marks. Published by Times Books.

²² PHR and HRF previously reported on the harmful effects of many of these techniques in their report *Leave No Marks: Enhanced Interrogation and the Risk of Criminality*.

²³ Basoglu M. et al. Torture vs. Other Cruel, Inhuman or Degrading Treatment: Is the Distinction Real or Apparent? *Archives Gen. Psychiatry* 277 (2007).

Conclusion

The newly released version of the May 2004 CIA Inspector General's report on Counterterrorism Detention and Interrogation Activities reveals the use of a number of previously undescribed techniques including:

- Forced Shaving
- Hooding
- Dietary Manipulation
- Prolonged Diapering
- Walling
- Confinement in a box

These techniques used alone or in combination may meet the definition of torture under US and international law. Legality aside, they are associated with high risk of physical and psychological harm, including harm that is enduring, in those subjected to these techniques. They also represent clear violations of well-established medical ethics governing the behavior of health professionals.

The report also confirms use of previously reported techniques, covered in the PHR and Human Rights First report *Leave No Marks*, such as isolation, forced nudity, stress positions, temperature manipulation, waterboarding, and other techniques which were used in ways that violated the torture statute and international law.

The Inspector General's report confirms much of what had been reported about the essential role played by health professionals in designing, deploying, monitoring and legitimizing the program of torture, but also raises disturbing new questions which require further investigation. The possibility that health professionals monitored techniques to assess and improve their effectiveness, constituting possible unethical human experimentation, urgently needs to be thoroughly investigated.

PHR has long called for full investigation and remedies including accountability for war crimes, and reparation such as compensation, medical care and psycho-social services. PHR also calls for health professionals who have violated ethical standards or the law to be held accountable through criminal prosecution, loss of license and loss of professional society membership where appropriate.