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ORIGINAL RESEARCH

Why Did U.S. Healthcare Professionals Become Involved in Torture During the War on Terror?

Myles Balfe

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Abstract This article examines why U.S. healthcare professionals became involved in "enhanced interrogation," or torture, during the War on Terror. A number of factors are identified including a desire on the part of these professionals to defend their country and fellow citizens from future attack; having their activities approved and authorized by legitimate command structures; financial incentives; and wanting to prevent serious harm from occurring to prisoners/detainees. The factors outlined here suggest that psychosocial factors can influence health professionals' ethical decision-making.

Keywords Doctor · Deviance · Torture · War on terror · Psychologist · Healthcare professional

Introduction

Healthcare professionals are often forces for good in the world. They heal the sick, care for the dying, and challenge injustice. Many of the benefits that humanity has experienced throughout the past century have come from breakthroughs driven by these professionals.

It is also the case, however, that healthcare professionals sometimes become involved in activities that challenge their professions' core healing ethos (Lifton 1988). For example, doctors and nurses were involved in destructive human experimentation in Nazi Germany and Imperial Japan (Lifton 1988; Harris 2002). Doctors punished political dissenters in Iraq by cutting off their ears (Reis et al. 2004), punished dissenters in the Soviet Union by committing them to insane asylums (Lifton 2004), and punished political opponents in Argentina by "disappearing" them (Perechocky 2014).

Torture is one form of deviant behaviour that healthcare professionals can engage in (Perechocky 2014). This is despite the fact that torture is unethical, and despite the fact that there are substantial laws and codes that should prevent health professionals from becoming involved in this activity (Singh 2003). The Tokyo Declaration for instance states that doctors must not facilitate torture or other cruel, inhuman, or degrading acts or be present when such acts are carried out (Singh 2003). Article two of the UN Convention Against Torture states that no circumstances whatsoever can justify or permit torture.

Why health professionals become involved in torture is therefore an important question. Although to date there has been extensive research published on health professionals' involvement in torture, the vast majority of this work has either taken either a legal or an ethical perspective. In contrast, this article explores the psychosocial factors which are associated with health professionals' participation in torture and other forms of cruel, inhuman, and degrading treatment (CID). The focus of this article is on the participation of U.S. doctors and psychologists in these activities during the War on Terror in the 2000s. Torture in this article is taken to

M. Balfe (✉)
Department of Sociology, University College Cork, Safari Building, O' Donovan's Road, Cork, Ireland
e-mail: m.balfe@ucc.ie

refer to the infliction of severe physical or mental pain or suffering on another person for the purposes of punishment, coercion, or information extraction. "Cruel, inhuman, and degrading" is taken to refer to a wider set of ethically deviant activities that health professionals actively used to undermine detainees' well-being or allowed to be used against detainees (Miles 2015). While there is now significant evidence documenting some U.S. professionals' involvement in human rights abuses, much of this evidence is descriptive in nature and does not explore in a significant way why health professionals became involved in these activities.

Method

Studies exploring U.S. health professionals' behaviour from their own perspectives are lacking, and much governmental evidence on this topic is still redacted. This article therefore draws on a number of academic and news media sources for information. Pubmed was searched for academic articles explaining why U.S. professionals took part in unethical conduct during the War on Terror; articles which discussed the ethics of professionals' participation in torture/enhanced interrogation, but which did not discuss the reasons for their participation in these activities, were rejected. Similarly, key media sources (*New York Times*, *The Atlantic*, *Washington Post*, and the *New Yorker*) were searched for similar information. Three major reports were also used as sources of evidence (IMAP/OSF 2013; SSIR 2014; Hoffman et al. 2015). The Institute on Medicine As A Profession/Open Society Foundations report provides a detailed and systematic description of U.S. military health professionals' torture-related behaviours during the War on Terror, and the SSIR report provides a detailed accounting of the Central Intelligence Agency's (CIA) torture programme, and the involvement of health professionals in it. The Hoffman report provides an in-depth exploration of why certain sectors within the American Psychological Association chose to facilitate the involvement of psychologists in harsh interrogation. Data from all included sources was extracted and then thematically organized to form the main sections of this article (dispositional reasons, defence of group, etc.).

Healthcare Professionals and the War on Terror

After 9/11 the U.S. government declared a global war on terrorism. Suspects were captured and detained at various "black sites" and military facilities around the world (Mayer 2005a). A number of these detainees were tortured, and health personnel who worked for the CIA or the U.S. military facilitated and oversaw this abuse (Adams, Balfour, and Reed 2006). Reflecting on U.S. interrogation policy during the 2000s, President Barack Obama acknowledged that "we tortured some folks" (Miller 2014). In fact, psychologists are now thought to have been largely responsible for the construction of the CIA's torture programme (Keller et al. 2014; SSIR 2014). While psychologists may not be typically viewed as healthcare professionals, one of their main roles in the enhanced interrogation programme was as safety officers who were there to monitor detainees' well-being.

United States health professionals who worked for security and military institutions passively and actively supported torture and other forms of CID. Passively, a number of professionals were aware that torture was happening and did not report it (IMAP/OSF 2013). In Abu Ghraib, for example, where detainee abuse was widespread, doctors did not report suspicious injuries such as dislocated shoulders (Miles 2004; Zernike 2004). Medics in Abu Ghraib also did not report that they had seen male detainees being forced to wear women's underwear, and nurses did not report that they had seen detainees being forced to wear sandbags over their heads and then stack themselves, naked, into human pyramids (Zernike 2004).

Beyond passively covering up and failing to report abuse, is also now clear that some professionals actively assisted in torturing detainees (IMAP/OSF 2013). One way that healthcare professionals did this was by handing detainees' medical information over to military interrogators (Slevin and Stephens 2004; IMAP/OSF 2013).

Health professionals, mainly doctors and psychologists, were also involved in the direct interrogation of detainees (IMAP/OSF 2013). Initially the involvement of these professionals in interrogation was ad-hoc and non-systematic (IMAP/OSF 2013). Relatively quickly, however, the role of health professionals in interrogations became formalized. Health professionals who acted as interrogators were classified by military and CIA authorities as "non-medical" personnel and seen as separate from the medical personnel who provided medical assistance to detainees (IMAP/OSF 2013).

Psychologists and doctors who acted as interrogators analysed detainees' psycho-medical information and advised CIA and military personnel about how to more effectively interrogate detainees (IMAP/OSF 2013; SSIR 2014). Psychologists working for the CIA advised in the development of "enhanced interrogation methods" such as water boarding, as did military Behavioural Science Consultation Teams, or BSCTS, which were composed of psychologists and medical professionals (IMAP/OSF 2013). Enhanced interrogation tactics that BSCTs recommended included the use of stress positions, confinement to small boxes, and exposure to white noise (IMAP/OSF 2013). Central Intelligence Agency psychologists and health professionals instructed interrogators to place detainees in solitary confinement, water board them, expose them to cold temperatures, deprive them of solid food, and keep them in a state of complete nakedness for extended periods of time (SSIR 2014). Central Intelligence Agency interrogators also threatened to harm the children of some detainees, as well as sexually abuse detainees' family members (SSIR 2014). Although health professionals mainly provided advice and strategies about how to interrogate detainees, in some cases CIA psychologists water boarded detainees (SSIR 2014). Medical approval was needed before detainees were subjected to enhanced interrogation (SSIR 2014). United States military and CIA medical personnel (separate from health professionals who worked as interrogators) were therefore present during interrogations to ensure that interrogation did not result in permanent physical injury or death (IMAP/OSF 2013).

Healthcare personnel were also involved in force-feeding detainees who went on hunger strike (IMAP/OSF 2013). Central Intelligence Agency medical officers used rectal feeding on detainees, sometimes with "excessive force," primarily as a means of behavioural control (SSIR 2014; Keller et al. 2014). While force-feeding may be seen as a degrading act that is nonetheless different from torture, in some instances it may become a form of torture. For example, there are reports of detainees in Guantanamo Bay being fed so forcefully that they would throw up blood when their feeding tubes were extracted (IMAP/OSF 2013), and medical professionals felt that rectal rehydration was "effective in getting [detainees] to talk" (Keller et al. 2014, 7), indicating that the psychological and physical pain of force-feeding was used for information extraction. This would meet the definition of torture outlined in the introduction.

Why Did U.S. Health Professionals Become Involved in Torture and Cruel, Inhuman, and Degrading Acts?

Dispositional Reasons

There are a number of reasons why healthcare professionals can become involved in torture. Some individuals appear to be "bad apples," and engage in deviant acts because they gain sadistic enjoyment from hurting others (Kelman 2005; Miles, Alencar, and Crock 2010).

However, U.S. health professionals who engaged in, covered up, or failed to report torture and other abuses during the War on Terror did not seem to do so because they liked harming other people; as the bioethicist Steve Miles has noted, they were not sadists (Beck 2014). One psychologist who was involved with the CIA programme noted that his job was not something that he sought out, "I didn't knock on the gate and say 'let me torture people'" (Risen and Apuzzo 2014). United States healthcare professionals in fact recognized that their involvement in enhanced interrogation could have a negative impact on themselves, noting "the toll it [waterboarding] will take on the team vs. the detainee" (SSIR 2014, 84).

Defence of Group

One important reason why U.S. health professionals became involved in torture was because they intended to defend their country from future attack. After 9/11 the United States believed that it faced an immediate existential threat. The fear of being attacked was pervasive (SSIR 2014). United States security professionals and institutions thought that there was a real risk that the United States could experience additional acts of terrorism if they did not acquire actionable information from detainees. The CIA and the U.S. military, under directions from senior administration sources, therefore came to a view that it was imperative to "take the gloves off" and use the full range of violent methods to extract intelligence from detainees (Mayer 2007; SSIR 2014). One of the psychologists who started the CIA's enhanced interrogation programme for example referred to this general context when he noted that "there was a tremendous amount of pressure not to let other Americans die" (Risen and Apuzzo 2014). Torture quickly came to be viewed as an effective way to acquire information in this context of an extremely high-pressured and fast-moving

situation where there was zero tolerance for risk (Ardau and Van Munster 2007). Some healthcare professionals who worked for U.S. security institutions supported the view that torture was necessary in order to defend the United States (IMAP/OSF 2013). One of the psychologists involved in the CIA enhanced interrogation programme noted that,

> … after a lot of soul searching, I agreed to do it … I went through my ethical obligations, and decided for me, the least worst choice [when deciding to become involved in enhanced interrogation or not] was to help save American lives. It felt like something was going to happen at any minute [another attack on the U.S.]. I felt like you had to do something. (Risen and Apuzzo 2014)

Another U.S. military psychologist noted that "the ethical consideration is always to do the most good for the most people. And America happens to be my client. Americans are who I care about. I have no fondness for the enemy" (Pope 2011, 155). Similarly, a medical officer who monitored Khaled Sheikh Mohammed's water boarding noted:

> … the team here apparently looks to use the water board … given the various pressures from home … I don't think they [other team members] believe that it will be possible to entirely avoid the water board given the high and immediate threat to the U.S. (SSIR 2014, 84)

Morality and Dehumanization

Health professionals who torture generally view their group as good and the group of the people who they are harming as bad and aggressive (Singh 2003; Harrington 2013). Black and white framing of torture is important as individuals will generally not engage in harmful conduct until they can justify the morality of their actions and can say that their actions are serving socially worthy or moral purposes (Bandura 2002). Torturers who develop a black and white moral ideology can see themselves as engaging in a transcendent mission to purify and heal the world (Kelman 2005)—purification and healing ideologies have been shown to have particular attraction for health professionals engaged in destructive behaviours (Lifton 1988). In the case of the War on Terror, the United States' struggle against Islamic extremism was characterized as a "monumental struggle of good versus evil" (Bush 2001). United States health professionals involved in this struggle would have been told (and possibly seen themselves as being) that they were on the side of right and morality, something which would have allowed them to justify the acts in which they were engaged.

Having a black and white perspective is useful for people involved in torture as it can make it easier to dehumanize those about to be hurt—viewing someone as fundamentally bad or evil makes it easier to think that that individual is deserving of punishment (Kelman 2005). Dehumanization is often further facilitated by the fact that the tortured are often racially or culturally different from their torturers (Hooks and Mosher 2005), and, as a result of their experiences of torture and being a detainee, they may look even more different, be unclean, and so on. One detainee in Guantanamo for example noted that force-feeding by medics took away his "honor and dignity" and turned him into something "like an animal" (IMAP/OSF 2013, 105). It has also been noted that many War on Terror detainees who were subjected to enhanced interrogation appeared, to their U.S. captors, to be alien and foreign (IMAP/OSF 2013). Some U.S. health professionals who worked in Guantanamo noted that they believed that Islamic terrorists were "malignant cells" with "brains that are structurally and functionally different from ours" (Bufacchi and Arrigo 2006, 363). Once someone is culturally or animalistically dehumanized it is much easier, even for someone with the intelligence and training of a medical doctor, to hurt, or to continue to hurt, them (Kelman 2005; Grodin and Annas 2007).

Healthcare professionals also medically dehumanized detainees and prisoners. This means that rather than viewing detainees as full persons, health professionals appeared to view them more as mechanistic objects to be subjected to scientific processes (Haque and Waytz 2012). Consequently health professionals frequently appeared to morally disengage from detainees (Haque and Waytz 2012); rather than talk about the ethics or morality of what was happening to detainees professionals focused on the procedures that were being done to them. For example when water boarding Khaled Sheikh Mohammed the medical officer stated that the "abdomen was somewhat distended and he expressed water when the abdomen was pressed … not concerned about regurgitated gastric acid," rather

the officer was "concerned about water intoxication and dilution of electrolytes" (SSIR 2014, 86). Discussing rectal hydration, medical officers wrote "while IV infusion is safe and effective, we were impressed with effectiveness of infusion." The same officer noted that "regarding the rectal tube, if you place it and open up the IV tubing, the flow will self-regulate, sloshing up the large intestines" (SSIR 2014, 100). Medical officers documented the interrogation techniques that they used or facilitated in exacting detailed (Keller et al. 2014).

Authorization by a Legitimate Authority

As noted, when health professionals become involved in violent medical deviance they are often labelled as "bad apples" and viewed as rogue elements. However for the most part health professionals are most at risk of becoming involved in torture and CID when they authorized to do so by the hierarchy or bureaucracy they work within (Pope and Gutheil 2009; Mostad and Moati 2008). Torture is almost always a crime of obedience that occurs as a result of instructions from authority (Kelman 2005). During the War on Terror, enhanced interrogation techniques and violent treatment of prisoners were authorized from the top of the command structure (Hooks and Mosher 2005; IMAP/OSF 2013). Military and security personnel at all levels, including health professionals, were informed that the tactics used against detainees were permissible, and in fact, desirable (Mayer 2005a; IMAP/OSF 2013,). One medical officer noted that "the waterboard was the bigstick and … HQ was more or less demanding that it be used early and often" (SSIR 2014, 85).

Generally if a practice such as water boarding is authorized by a legitimate command structure, individuals who are subject to that command structure will feel a duty to obey (Kelman 2005). Individuals will often allow the authority to determine what their behaviour will be and will not experience themselves as free moral agents able to make personal moral choices (Blass 1999; Bandura 2002; Tyler 2004; Kelman 2005). United States military professionals initially resisted the use of enhanced interrogation techniques but acquiesced to their use when they were ordered to do so by their civilian leaders (IMAP/OSF 2013). A U.S. military psychiatrist reported that he experienced significant pressure from his chain of command to subject detainees to enhanced interrogation methods that he personally felt uncomfortable with (IMAP/OSF 2013). Another young U.S. psychologist reported that he experienced significant pressure to teach interrogators how to sexually humiliate detainees and that, although he was "devastated to have been part of this," he still taught interrogators how to do so (IMAP/OSF 2013, 36–37). A number of C.I.A. medical personnel became extremely upset when they witnessed water boarding but permitted the water boarding to occur because they were instructed to do so by their command authority (SSIR 2014). These findings might be surprising given the health professions' traditional association with independence and autonomy; though these professionals also have strong traditions of conformity and obedience to authority (IMAP/OSF 2013). It is possible that there may be a particular kind of authority-orientated personality who is attracted to security institutions, and individuals who are strongly resistant to authority might be screened out of military training (Grodin and Annas 2007). For example, before physicians were sent to Guantanamo, the military screened them to ensure that they did not morally object to force-feeding so as to ensure that they would obey orders to force-feed if instructed to do so (IMAP/OSF 2013). Health professionals who work for the security services are furthermore trained to obey hierarchical commands and subject to employment arrangements that formally subordinate them to a chain of command (Pont, Stover, and Wolf 2012). In these types of institutions, obedience to authority may be seen as more important than medical ethics and autonomy (Mostad and Moati 2008; Vesti and Lavik 1991), and professionals may see their fiduciary responsibility as lying with the institution rather than with the "patient" (London 2005). Furthermore, most healthcare related abuses in the War on Terror occurred in prisons, isolated military facilities, and CIA black sites (Mayer 2007). In those spaces the flow of information and personnel between the institution and the outside world would be tightly controlled. Health professionals would have lacked alternative role models and information sources that could challenge their orders to become involved in torture, while psychological pressures on health professionals to obey those orders would have been intensified (Olson, Soldz, and Davis 2008).

Finally, it is important to note that in following the orders of a military or security institution that they believe to be legitimate, health professionals give legitimacy to those orders (Lifton 2004). The transfer of prestige and legitimacy from the health profession on to the security institution and its orders stems from the

moral and social prestige of health professions, particularly medicine. This is one of the reasons why institutions involved in deviant behaviour are so keen to enrol doctors in their programmes (Lifton 2004).

Legal Approval and Euphemistic Labelling

United States healthcare professionals' involvement in medical deviance was also facilitated through legal means. Generally health professionals will only become involved in torture if those acts are legally sanctioned. In the case of the War on Terror, for example, legal approval for enhanced interrogation was granted by senior government lawyers; though many researchers now argue that these lawyers used "bad faith" interpretations of the law to facilitate their own purposes (Mayer 2005a; IMAP/OSF 2013).

States and organizations involved in torture often go to significant legal and semantic lengths to redefine torture as "something else" (Kelman 2005), a process that Physicians for Human Rights (Keller et al. 2014, 8) have labelled "legal farce." For example in the War on Terror acts of torture were often euphemistically framed and sanitised as abuse or "enhanced interrogation techniques," acts that were seen as less serious than torture (Hooks and Mosher 2005). Torture itself was redefined by U.S. lawyers as an act that must inflict pain equivalent to organ failure or death; lawyers said that for suffering to amount to torture it must result in psychological harm lasting for years (Adams, Balfour, and Reed 2006; Calkins 2010, Rubenstein and Xenakis 2010).

Redefining torture as "something else" serves to create and maintain an "alternate reality" where torture is no longer torture; this makes it easier for health professionals to become involved in torture because they are protected from the full moral implications of their acts and they can view what they are doing as less hazardous than torture (Crelinsten 2003; Grodin and Annas 2007). Redefining hunger striking as attempted suicide can create a situation where health professionals feel duty and morally bound to intervene to "protect" detainees, even though their intervention contravenes international guidelines and is harmful to the "patient's" mental health. Adams and colleagues (2006) use the phrase "administrative evil" to refer to the twisting of the law in the War on Terror in such a way that people risk engaging in acts of evil without being aware that they are doing anything wrong; in fact, they might believe that what they are doing is good. One outside expert familiar with the C.I.A interrogation programme noted "It was the intentional and systematic infliction of great suffering masquerading as a legal process. It is just chilling" (Mayer 2007).

In addition to legally redefining torture, the law, together with bureaucratic guidelines, was also used to redefine health professionals' roles and ethical responsibilities so as to more easily enable their involvement in torture. Lawyers working for U.S. security institutions sought to redefine the role of doctors who worked as interrogators by limiting their professional duty to "do no harm." The military argued that a medical degree was merely a "certificate of skill" that could be used for any purpose, including harmful purposes, and "not a sacramental vow" (Koch 2006, 249).

While legally redefining torture as enhanced interrogation was necessary to enrol healthcare professionals, healthcare professionals involvement was itself necessary to define enhanced interrogation as legal. One of the most striking features of the SSIR report was the extent to which CIA, military, and government lawyers sought medical approval for various techniques, "in particular sleep deprivation, water dousing, and the waterboard" (SSIR 2014, 415). Health professionals were both the target of legal redefinitions of torture and crucial enablers of that redefinition. Much like their obeying of torture orders legitimized those orders, their acceptance of the legality of enhanced interrogation legitimized the legality of U.S. torture tactics. In fact, the need to have enhanced interrogation techniques medically approved was a key factor in drawing CIA health personnel into the torture programme. Initially CIA health personnel took a fairly passive monitoring role over the programme, but in order to determine the legality of the techniques that were being used they eventually became active participants (Keller et al. 2014). These health professionals therefore demonstrated an escalation of commitment over time.

It is also important to note that despite the efforts outlined here to redefine both torture and healthcare professionals responsibilities towards prisoners, a number of CIA behavioural scientists did not "buy into" these redefinitions. Inside the CIA,

> … there was strong internal opposition to the new techniques. "Behavioral scientists said, 'Don't even think about this!' They thought officers could be prosecuted." (Mayer 2007)

In 2003 a CIA chief interrogator said that the brutal treatment of detainees was a "train wreck" waiting to happen and that he did not want to be associated with what was happening in any way (SSIR 2014). There were strong fears within the CIA about the risks of eventual political retribution for the programme (Mayer 2007). In fact, concerns about legal risk were likely one reason why the CIA eventually outsourced much of its interrogation programme to external psychologists. Those psychologists themselves were also very concerned about protecting themselves from future legal risk and successfully requested that the CIA cover their legal bills if the psychologists were pursued through the courts for torture (SSIR 2014).

Prevention of Harm and Risk Management

United States health professionals also became involved in torture because they believed that without their involvement the person being tortured would have been at a greater risk of experiencing suffering. A CIA officer noted that

> … the role of C.I.A. medical officers in the detainee programme is and always has been and always will be to ensure the safety and the well-being of the detainee. The placement of medical officers during the interrogation techniques represents an extra measure of caution. (SSIR 2014, 113)

Military doctors noted that "we only do what is medically necessary in a humane and compassionate manner" (IMAP/OSF 2013, 103). Health professionals working for security institutions often viewed the tortured as "patients" (IMAP/OSF 2013). For example, U.S. military doctors who monitored enhanced interrogations were labelled as risk-reducing "safety officers" and saw their role as preventing interrogators from "going too far" and permanently physically hurting or damaging detainees (medics appeared to be largely unconcerned about damage to detainees' mental health) (IMAP/OSF 2013). Doctors spent considerable amounts of time and effort monitoring detainees' enhanced interrogations and comparing them to model interrogation descriptors outlined in interrogation guidelines (IMAP/OSF 2013). If an actual interrogation began to deviate too much from the techniques authorized by the guidelines—for example, if detainees were put in stress position for more than forty-eight hours, or were water boarded too often—then medical staff would intervene (Rubenstein and Xenakis 2010; SSIR 2014). Being labelled as a safety officer may have provided these professionals with comforting rationalizations about their actions and their roles, thereby allowing them to remain in the torture situation (IMAP/OSF 2013).

However the reality was that on many occasions U.S. health professionals did not intervene when detainees were suffering or in pain (IMAP/OSF 2013). Military personnel sometimes viewed detainees' health problems, such as suicidal ideation, as a form of asymmetric warfare (IMAP/OSF 2013). Hunger strikes could be interpreted as terrorism-related activities: "the will to resist of these detainees is high. They are waging their war, their jihad against America, and we just have to stop them" (Zagorin 2006). In some situations medical care was withheld from detainees if they were not perceived to be cooperating (Keller et al. 2014). In other situations if a healthcare professional believed that a detainee was too injured to be subjected to enhanced interrogation, interrogators could simply get another health professional to say that the detainee could be interrogated (SSIR 2014). Health professionals who were present in order to prevent "behavioural drift" could drift themselves; in at least one instance a safety officer demanded to participate in the interrogation as an interrogator (SSIR 2014). In some interrogations the interrogator also doubled as the medical officer who was meant to govern that interrogator's behaviour (SSIR 2014). Medical officers in many cases appeared to identify with the goals of interrogation over patient care (Keller et al. 2014).

Medical officers were present to prevent risk—however it is arguable that the true "patients" who these health professionals were concerned about protecting from risk were interrogators and the interrogating institution. The role of medical monitors was not to prevent detainees from experiencing pain and suffering but rather to avoid them experiencing severe pain and damage that could legally constitute torture (as redefined by administration lawyers) and thereby expose the interrogators and the institution to legal consequences (IMAP/OSF 2013). In some situations where detainees were being hit in the face, medics advised that the detainees be hit around the eye, not in it, possibly because it would leave less of a mark (Mayer 2005b). One CIA medical officer noted "things are slowly evolving form [sic] OMS [Office of Medical

Services] being viewed as the institutional conscience and limiting factor to the ones who are dedicated to maximising the benefit and keeping everyone's butt out of trouble" (SSIR 2014, 87). Even where professionals felt that interrogators were exceeding medical interrogation guidelines, those professionals could be prevented from reporting their concerns because of the risk of establishing "grounds for further legal action" (SSIR 2014, 472). Additionally in a least some instances if detainees became very ill they could be refused medical care in local hospitals because of concerns that this would reveal information about the CIA's blacksite location and activities (SSIR 2014).

Diffusion of Responsibility

Involvement in torture appeared to be facilitated in situ through diffusion of responsibility. This meant that each enhanced interrogation sequence was broken down into its separate components, and different individuals were tasked with carrying out a different component of the entire sequence. In relation to water boarding, one person often poured the water on the prisoner's head; another person (usually the health professional) monitored the prisoner's medical signs and symptoms; another person (sometimes a health professional) asked the questions. Something similar usually happens in relation to health professional involvement in executions; the individuals who strap prisoners down are often different from the ones who insert IVs who are different from the people who administer the lethal injection drugs (Gawande 2006). This splitting of roles allows feelings of guilt and responsibility to be diffused throughout the group. No one person sees him or herself as being morally responsible for everything and, as a result, the health professional can more easily take part in what is happening. On a systems level, the individuals authorizing enhanced interrogation were different from the ones carrying it out, and there were barriers in place preventing interrogators on the ground from interacting with higher level policymakers. One of the psychologists involved in the C.I.A. programme felt that "I was just a cog in the machine" (Risen and Apuzzo 2014).

Bystanders

Steve Miles (Beck 2014) argues that doctors and psychologists were, on a macro-policy level, "built in to the entire torture system. They weren't simply bystanders who were called in to respond when the system went off the rails." However, on a micro-level, health professionals' involvement in torture appeared to be facilitated by the fact that they were often bystanders to deviance. Behavioural Science Consultation Teams were recruited to give advice to interrogators, safety officers recruited to observe detainees' health statuses, rather than to torture themselves. CIA guidelines said that the "role of the ops psychologist is to be a detached observer" (SSIR 2014, 72). In relation to the interrogation of the detainee Abu Zubaydah, CIA records noted,

> … other personnel … including C.I.A. medical personnel … were only to observe … [as] security personnel entered the cell, shackled and hooded Abu Zubaydah and removed his towel (Aub Zubaydah was then naked). Without asking any question, the interrogators placed a rolled towel around his neck as a collar … to slam Abu Zubaydah against a concrete wall. (SSIR 2014, 40–41)

Behavioural Science Consultation Team psychologists indicated that their role was to "observe interrogation" (Oskie 2005, 2533). Being a bystander enables an individual to be present during a deviant act, or encounter it afterwards, but not do anything about it because they do not see themselves as personally responsible for that act—someone else is perpetrating it (Zimbardo 2007). Bystanding health professionals often fail to intervene to stop deviance either because they deny the seriousness of what is happening or because they are unsure about what to actually do. Even where bystanders are disturbed by what they see happening, they can surrender agency and moral responsibility for what is happening to other actors in the situation. The medical observer of Abu Zuadayah's interrogation noted,

> … no useful information so far … he did vomit a couple of times during the water board … it's been 10 hours since he ate so this is surprising and disturbing … I'm heading back for another water board session. (SSIR 2014, 41)

There might also be concerns about the risks of stepping out of a bystander role to protect someone who the organization determines is a dangerous criminal. People generally are most likely to remain as bystanders where authorities convey to organizational employees that unethical and illegal behaviour is necessary

in certain circumstances, such as when combating terrorism or when punishing hardened criminals (Crelinsten 2003). Health professionals are further likely to remain bystanders when abuse reporting structures are unclear, as they were in the early years of the U.S. invasion of Iraq (IMAP/OSF 2013). Health professionals who participate in torture or execution as bystanders can use a variety of neutralization techniques to remain in the situation including "just world thinking," where they decide that the detainee or condemned person must have done something to deserve their fate, such as being involved in terrorism (Crelinsten 2003). Health professionals are also likely to remain bystanders if they feel their own safety depends on that of their co-interrogators, or when they want to save their ability to intervene for the most extreme cases of abuse (Marks 2005). This would have been the case for many U.S. health professionals working abroad in conflict situations such as Iraq and Afghanistan. A health professional remaining a bystander when abuse is occurring can be viewed as a form of evil behaviour, however (Zimbardo 2007), not least because the passivity of health professionals can allow an interrogators' deviant interpretation of the situation to strengthen (Crelinsten 2003).

Financial Incentives

Health professionals may also become involved in torture for self-interest and self-promotional reasons (Singh 2003). Steve Miles has noted that "the docs who get involved in this, number one, are careerists. They get involved for rank and career" (Beck 2014). The CIA itself felt that some U.S. healthcare professionals involvement in enhanced interrogations appeared to be partly influenced by financial and professional considerations (SSIR 2014; Keller et al. 2014). The Hoffman report (2015) argues that key sectors within the American Psychological Association (APA) supported the amending of APA ethical guidelines so as to enable the participation of psychologists in potentially harsh interrogations. They did this in order to maintain positive relationships with the U.S. Department of Defence, ensure a steady stream of grants and contracts for psychologists and to reinforce the power of psychology vis-a-vis psychiatry. It also notes that key actors within the American Psychological Association went to great lengths not to inquire into psychologists' participation in harsh interrogations. The APA, Soldz (2011, 16) argues, was "full of people without inquiring minds." The psychologists who developed the CIA programme were paid eighty-one million dollars for their roles as enhanced interrogation consultants (SSIR 2014). These psychologists were paid per interrogation procedure, a rate of $1800 for water boarding and were also allowed to assess the effectiveness of their own work (SSIR 2014). A situation was put in place, therefore, whereby Central Intelligence Agency funded psychologists were recommending enhanced interrogation techniques that they would personally financially benefit from (Keller et al. 2014). These psychologists' contact with the CIA has consequently been described as a "lucrative seven-year ride" (Shane 2009). Some CIA medical officers expressed strong concerns about the organization financially incentivizing these psychologists to perform enhanced interrogations, saying that it led the psychologists to have a vested stake in what they were doing which created conflicts of interest:

> OMS concerns about conflict of interest were nowhere more graphic than in the setting in which the same individuals applied an EIT which only they were approved to employ, judged both its effectiveness and detainee resilience, and implicitly proposed continued use of the technique—at a daily compensation reported to be 1800/day, or four times that of interrogators who could not use the technique. (SSIR 2014, 66)

Health professionals may also be worried about risks to their careers if they do not participate in torture or if they report having seen it (Sonntag 2008). In Abu Ghraib, for example, junior personnel such as staff nurses who witnessed abuse and torture appeared to be afraid to speak up out of fear that they could lose their jobs or otherwise be disciplined (Zernike 2004). The social and professional costs of resisting command pressure may be so great that health professionals may wish to avoid these costs, even if it means compromising their ethics and their dignity as a person (IMAP/OSF 2013, 36-37).

Discussion

The U.S. healthcare professionals involved in enhanced interrogation would have been among the best trained in the world and in all likelihood would have had good knowledge of military and healthcare ethics and their legal responsibilities. However despite this they still

found themselves committing, facilitating, or observing abuses, even when many of them were disturbed by those abuses. This points to the fact that psychosocial factors—of the kind outlined in this article—can influence ethical decision-making (Lifton 2004; Zimbardo 2007). In the case of U.S. healthcare professionals in the War on Terror, many of these reasons appeared—on the surface—to be understandable, though as outlined below, I believe that they are probably ultimately unjustifiable and harmed themselves and the institutions for which they worked. Health professionals were obeying instructions from what they considered to be legitimate authorities. They were seeking to defend their country. They were attempting to prevent their fellow citizens from being murdered by religious and political extremists. A U.S. military officer, commenting on why psychologists became involved in the U.S. torture programme said "I felt their primary motivation was they thought they had skills and insights that would make the nation safer" (Shane 2009). However he also noted that a "good person in extreme circumstances can do horrific things" (Shane 2009). In the pursuit of their goals during an extreme time, some U.S. healthcare professionals in the War on Terror committed acts which significantly compromised their ethics or allowed those acts to be committed.

The health professionals who became involved in enhanced interrogation appeared ultimately to justify their actions by taking a utilitarian position. Their argument was that it was necessary to harm a small number of detainees in order to protect a large number of lives and that without their involvement detainees would suffer at the hands of inexperienced military interrogators. They also said that they were authorized to participate in enhanced interrogations by their lawful superiors and professional organizations. There are a number of problems with these arguments. Firstly, the use of torture is ethically problematic from a utilitarian perspective simply because torture does not reliably produce quality information. Torture can generate false information, which could lead to disastrous choices and send interrogators down blind alleys (Mayerfield 2008). The CIA itself, after hundreds of hours of interrogation experiments via programmes such as MK Ultra, determined that torture was operationally challenging (Miles 2015). When individuals attempt to justify torture it is generally through the "ticking time bomb" argument, which suggests that unless torture is used immediately there will be a risk that other people in the terrorist's network will commit an atrocity. Many of the individuals subjected to enhanced interrogation in CIA black sites, however, were interrogated for extended periods of time. Any actionable information that they would have had would likely have been degraded by the length of time that they were interrogated, rendering the ticking time bomb imperative less relevant.

Utilitarian arguments must also take into account the total impact of the actions being considered. It is possible that an innocent person who is tortured, or those who care for them, will become an enemy of the torturer's group. The American Psychological Association experienced years of internal upheaval and reputational damage following revelations of psychologists' involvement in enhanced interrogation (Hoffman et al. 2015). For military institutions torture can have a number of serious negative impacts, including loss of honour. It is unclear if and how U.S. healthcare professionals considered these wider impacts of their actions when engaging in their ethical calculus.

Other explanations why health professionals became involved in CID and torture are also problematic. Health professionals argued that their involvement was necessary in order to prevent detainees from being abused; however in reality their presence allowed that abuse to occur. Given the focus on risk management in the enhanced interrogation programme, it is difficult to see how torture would have been allowed to happen without health professionals being present. Health professionals also said that they became involved in enhanced interrogation because they were authorized to do so by legitimate authorities, a variation of the "just following orders" defence. However the extent to which these orders were actually morally and legally legitimate has been intensely debated. As noted (Hoffman et al. 2015), the American Psychological Association's decision to support the involvement of psychologists in interrogation stemmed partly out of political and economic necessity. In effect, this appeared to be an organization that could not necessarily be uncritically relied upon for objective moral guidance or approval for such a serious matter. There were also significant disagreements at high levels within the U.S. government and legal community about the legality of enhanced interrogation. Luban (2007) notes that the legal opinions authorizing enhanced interrogation were referred to as "cover your ass" opinions by non-government lawyers. In this highly ambiguous situation health professionals should have refrained from engaging in harmful behaviours and resorted to "do no harm" as their first ethical

principle. It is problematic to say that your actions were justified because you were following the law, when it is widely suspected that the law itself may be illegal.

Furthermore, there is the simple and terminal fact that "just following order" has, since Nuremberg, never been a sufficient justification for the commission of human rights abuses. Legal sanction for risky actions does not remove personal accountability for decision-making from the individual health professional (Godlee 2009). External legal and command environments can be fluid. The CIA, for example, repudiated torture in the 1980s and 1990s as the wider policy environment at the time—publicly at least—condemned torture. It was only after 9/11 that the CIA's policies and attitudes changed and legal prohibitions on torture were swept aside. Health professionals must not surrender their ethical decision-making to institutions whose ethical compass can shift dramatically in response to external shocks.

Conclusion

The IMAP/OSF report contains a series of important recommendations for ensuring that similar abuses do not occur in the future, such as improved ethics training for health professionals who work for the military and intelligence services, ensuring security institutions do not seek to redefine healthcare professionals' roles and ethical responsibilities, and ensuring that civilian professional associations punish health professionals who become involved in abuses. Healthcare professionals must never be financially incentivized to participate in torture or other forms of cruel, inhuman, or degrading treatment. Ethics training should stress that professionals cannot necessarily rely for their ethical compass on the institution for which they work.

As far as possible it is important to reduce the risk of health professionals becoming involved in torture. Much of the information that is generated through torture is useless (SSIR 2014). Involvement in torture can blur the line between healing and destruction. It can cause professionals to have dual loyalties, both to patients in their care and to the state and the security services. The involvement of health professionals can increase the risk that other people will believe that torture is morally and legally acceptable. Torture can also corrupt those who engage in it, creating feelings of omnipotence in interrogators and leading to escalating cruelty (Hajjar 2009). The *New Yorker* reporter Jane Mayer interviewed an FBI agent who said about torture, "brutalization doesn't work. We know that. Besides, you lose your soul" (Mayer 2005a). This statement is as applicable for health professionals as it is for anyone else.

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