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FAX COVER SHEET
Central Intelligence Agency



Washington, DC 20505

15 January 2005

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Number of pages (including cover sheet): 35

Comments: (S//NF) Dan, Latest OMS Guidelines (came out while I was out of the office. I haven't studied to see what changed from the last version I sent you. [REDACTED])

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OMS GUIDELINES ON MEDICAL AND PSYCHOLOGICAL SUPPORT TO
DETAINEE RENDITION, INTERROGATION, AND DETENTION
December 2004

The following guidelines offer general references for medical officers supporting the rendition and detention of terrorists captured and turned over to the Central Intelligence Agency for interrogation and debriefing. There are three different contexts in which these guidelines may be applied: (1) during the period of rendition and initial interrogation, (2) during the more sustained period of debriefing at an interrogation site, and (3) [REDACTED]

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44-370 p.3

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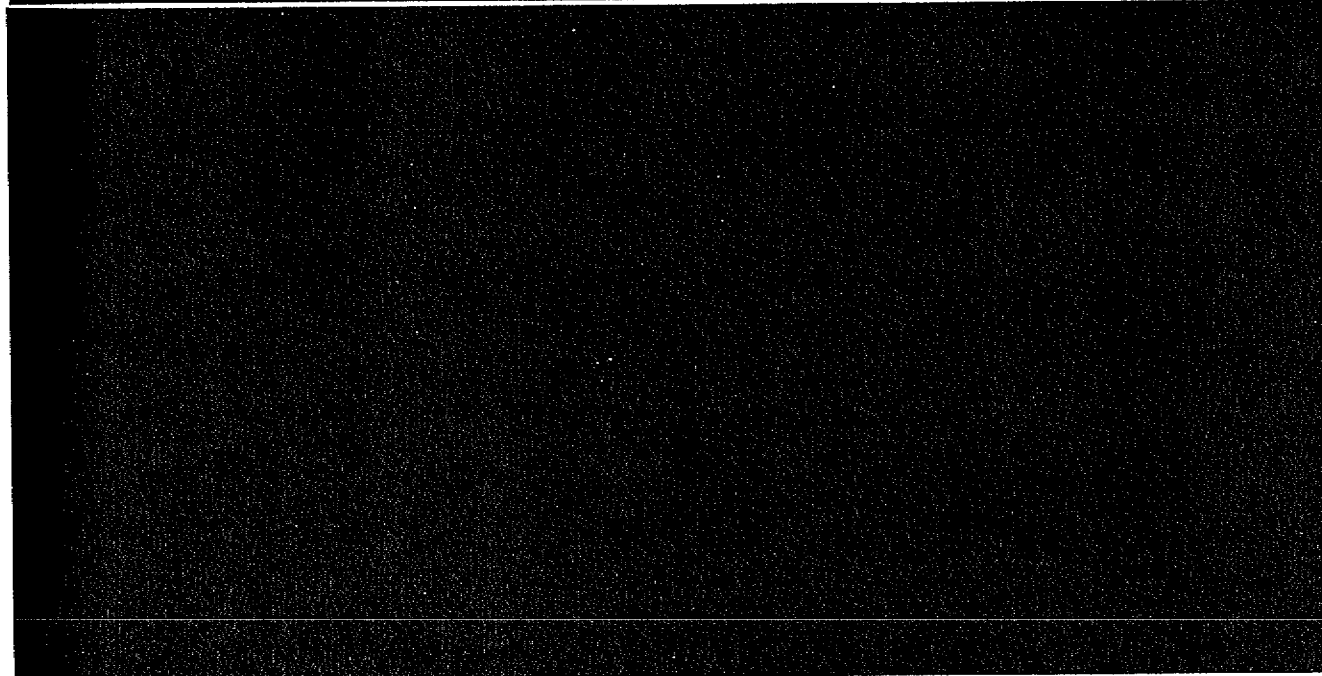
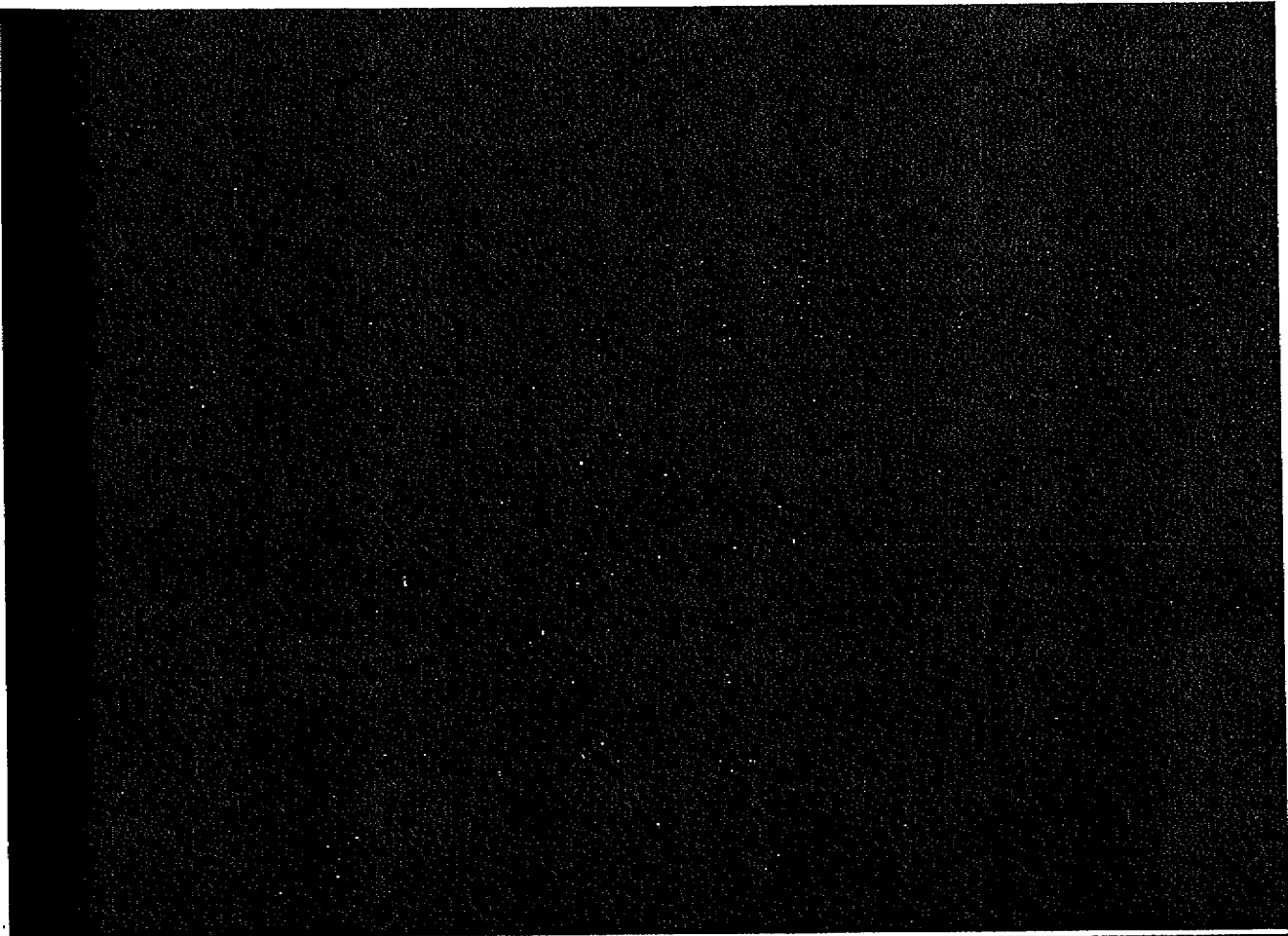
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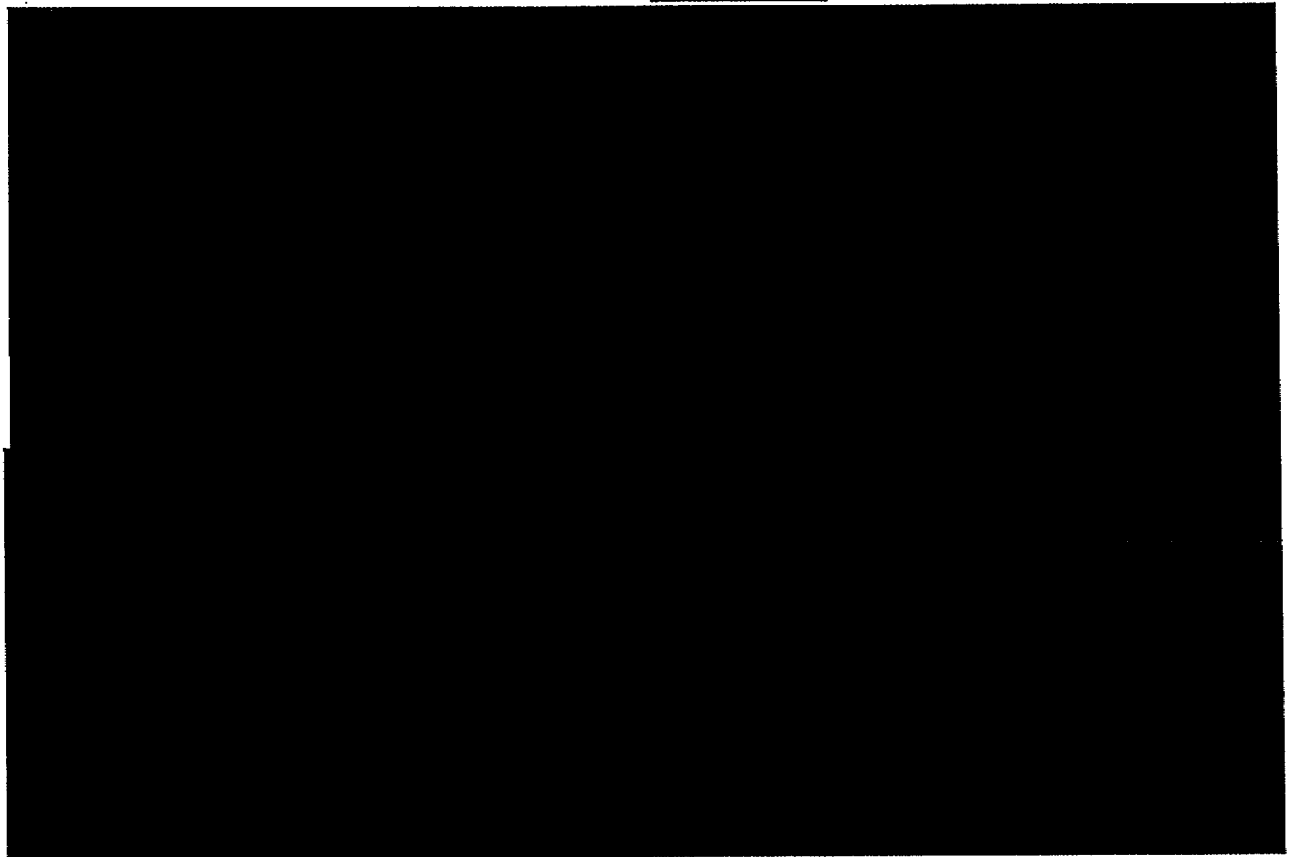
Guidelines for the use of sedatives.

At times it may be necessary to sedate a subject during the initial transfer or subsequent transport, to protect either the subject or the rendition security team.

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DETENTION AND INTERROGATION

General intake evaluation

New detainees are to have a thorough initial medical assessment upon arrival at the first Agency detention facility, with a complete, documented history and physical addressing in depth any chronic or previous medical problems. This assessment should especially attend to cardio-vascular, pulmonary, neurological and musculoskeletal findings. [REDACTED]

Vital signs and weight should be recorded, and blood work drawn [REDACTED]

[REDACTED]

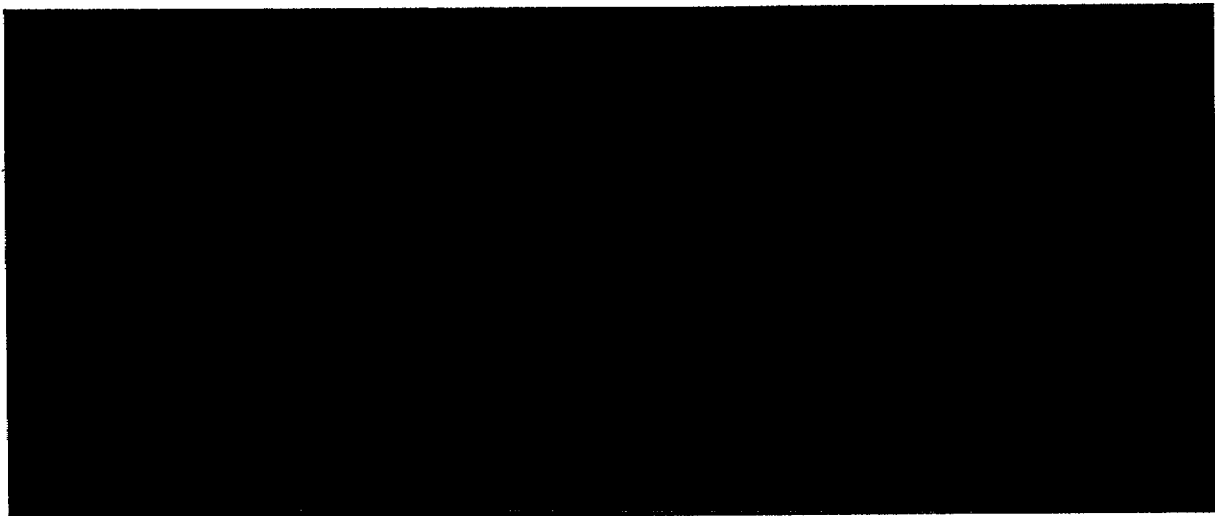
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Captured terrorists turned over to the C.I.A. for interrogation may be subjected to a wide range of legally sanctioned techniques, all of which are also used on U.S. military personnel in SERE training programs. These are designed to psychologically "dislocate" the detainee, maximize his feeling of vulnerability and helplessness, and reduce or eliminate his will to resist our efforts to obtain critical intelligence.

Sanctioned interrogation techniques must be specifically approved in advance by the Director, CTC in the case of each individual case. They include, in approximately ascending degree of intensity:

- Shaving
- Stripping
- Hooding
- Isolation
- White noise or loud music (at a decibel level that will not damage hearing)
- Continuous light or darkness
- Uncomfortably cool environment
- Dietary manipulation (sufficient to maintain general health)
- Shackling in upright, sitting, or horizontal position
- Sleep deprivation (up to 48 hours)
- Attention grasp
- Facial hold
- Insult (facial) slap
- Abdominal slap
- Sleep deprivation (over 48 hours)
- Water Dousing and tossing
- Stress positions
 - on knees, body slanted forward or backward
 - leaning with forehead on wall
 - leaning on fingertips against wall
- Walling
- Cramped confinement (Confinement boxes)
- Waterboard

In all instances the general goal of these techniques is a psychological impact, and not some physical effect, with a specific goal of "dislocat[ing] his expectations regarding

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the treatment he believes he will receive...." The more physical techniques are delivered in a manner carefully limited to avoid serious physical harm. The slaps, for example, are designed "to induce shock, surprise, and/or humiliation" and "not to inflict physical pain that is severe or lasting." To this end they must be delivered in a specifically prescribed manner, e.g. with fingers spread. Walling is performed only against a springboard designed to be loud and bouncy (and cushion the blow). All walling and most attention grasps are delivered only with the subject's head solidly supported with a towel to avoid extension-flexion injury.

OMS is responsible for assessing and monitoring the health of all Agency detainees subject to "enhanced" interrogation techniques, and for determining that the authorized administration of these techniques would not be expected to cause serious or permanent harm.¹ "DCI Guidelines" have been issued formalizing these responsibilities, and these should be read directly.

Advance Headquarters approval is required to use any physical pressures; technique-specific advanced approval is required for all "enhanced" measures and is conditional on on-site medical and psychological personnel² confirming from direct detainee examination that the enhanced technique(s) is not expected to produce "severe physical or mental pain or suffering." As a practical matter, the detainee's physical condition must be such that these interventions will not have lasting effect, and his psychological state strong enough that no severe psychological harm will result.

The medical implications of the DCI guidelines are discussed below. [REDACTED]

¹ The standard used by the Justice Department for "mental" harm is "prolonged mental harm," i.e., "mental harm of some lasting duration, e.g., mental harm lasting months or years." "In the absence of prolonged mental harm, no severe mental pain or suffering would have been inflicted." Memorandum of August 1, 2002, p. 15.

² [REDACTED]
Unless the waterboard is being used, the medical officer can be a physician or a PA; use of the waterboard requires the presence of a physician.

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~~TOP SECRET~~ [REDACTED]Medical treatment

Adequate medical care shall be provided to detainees, even those undergoing enhanced interrogation. Those requiring chronic medications should receive them, acute medical problems should be treated, and adequate fluids and nutrition provided. [REDACTED]

[REDACTED]

[REDACTED]

The basic diet during the period of enhanced interrogation need not be palatable, but should include adequate fluids and nutrition. Actual consumption should be monitored and recorded. Liquid Ensure (or equivalent) is a good way to assure that there is adequate nutrition. Individuals refusing adequate liquids during this stage should have fluids administered at the earliest signs of dehydration. [REDACTED]

[REDACTED] If there is any question about adequacy of fluid intake, urine output also should be monitored and recorded.

All medical officers remain under the professional obligation to do no harm. [REDACTED]

[REDACTED]

Medical officers must remain cognizant at all times of their obligation to prevent "severe physical or mental pain or suffering."

Uncomfortably cool environments

Detainees can safely be placed in uncomfortably cool environments for varying lengths of time, ranging from hours to days. [REDACTED]

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[REDACTED]

Core body temperature falls after more than 2 hours at an ambient temperature of $10^{\circ}\text{C}/50^{\circ}\text{F}$. At this temperature increased metabolic rate cannot compensate for heat loss. The WHO recommended minimum indoor temperature is $18^{\circ}\text{C}/64^{\circ}\text{F}$. The "thermoneutral zone" where minimal compensatory activity is required to maintain core temperature is $20^{\circ}\text{C}/68^{\circ}\text{F}$ to $30^{\circ}\text{C}/86^{\circ}\text{F}$. Within the thermoneutral zone, $26^{\circ}\text{C}/78^{\circ}\text{F}$ is considered optimally comfortable for lightly clothed individuals and $30^{\circ}\text{C}/86^{\circ}\text{F}$ for naked individuals.

[REDACTED]

If there is any possibility that ambient temperatures are below the thermoneutral range, they should be monitored and the actual temperatures documented.

[REDACTED]

At ambient temperatures below $18^{\circ}\text{C}/64^{\circ}\text{F}$, detainees should be monitored for the development of hypothermia.

[REDACTED]

Dietary manipulation during interrogation

During the interrogation phase, detainee diets may be modified to enhance compliance with interrogators and facilitate movement to the debriefing phase. Detainees health should not be jeopardized by such restrictions, however, so medical officers should attend to adequate fluid and nutrition intake. In general, daily fluid and nutritional requirements may be estimated using the following formulae:

Fluid requirement: $35 \text{ ml} / \text{kg} / \text{day}$. Will alter with ambient temperature, body temperature, level of activity, intercurrent illness. Monitoring of fluid intake and of urine output and specific gravity may be necessary when the medical officer suspects the detainee is becoming dehydrated.

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Energy requirement (male): $900 + 10 \times \text{weight in kilograms}$ for basal Kcal requirement; multiply by 1.2 for sedentary activity level, 1.4 for moderate activity level.

Widely available commercial weight loss programs in the US employ diets of 1000 Kcal / day for sustained periods of weeks or longer without required medical supervision in persons voluntarily seeking to lose weight; these diets have proven safe and effective in inducing short term weight loss. Franchised medically supervised programs may employ diets with even lower daily calorie provision (as low as 500 Kcal / day), but do entail some risk because of alterations in serum electrolytes.

Should the interrogation team choose to limit the detainee's food intake, OMS recommends a minimum intake of 1500 Kcalories / day, recognizing that intakes of 1,000 Kcal are safe and sustainable for weeks at a time. The nutrients may be presented as either a balanced liquid supplement, such as Ensure Plus (360 Kcal / can), or a reduction in the detainee's normal solid food intake. If enhanced interrogation methods are contemplated, a liquid diet is appropriate to minimize risk to the detainee of aspiration; a liquid diet is mandatory if use of the waterboard is being contemplated.

[REDACTED]

Water dousing

[REDACTED]

guidelines for a discussion of water dousing techniques, which allow for water to be applied using either a hose connected to tap water, or a bottle or similar container as the water source. Care must be taken to keep water away from the face to avoid risk of accidental ingestion or aspiration.

OMS guidelines for exposure to water are:

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- For water temperature of 41 F / 5 C - total duration of exposure not to exceed 20 minutes without drying and rewarming.
- For water temperature of 50 F / 10 C - total duration of exposure not to exceed 40 minutes without drying and rewarming.
- For water temperature of 59 F / 15 C - total duration of exposure not to exceed 60 minutes without drying and rewarming.

These standards are derived from submersion studies, and represent 2/3 of the time at which hypothermia is likely to develop in healthy individuals submerged in water, wearing light clothing. In our opinion, a partial dousing, with concomitant less total exposure and potential heat loss, would therefore be safe to undertake within these parameters. The total dousing time includes both the actual dousing and time in wet clothing.

[REDACTED]

[REDACTED]

White noise or loud music

As a practical guide, there is no permanent hearing risk for continuous, 24-hours-a-day exposures to sound at 82 dB or lower; at 84 dB for up to 18 hours a day; 90 dB for up to 8 hours, 95 dB for 4 hours, and 100 dB for 2 hours. If necessary, instruments can be provided to measure these ambient sound levels.

[REDACTED]

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~~TOP SECRET~~ [REDACTED]Shackling and prolonged standing

Shackling in non-stressful positions requires only monitoring for the development of pressure sores with appropriate treatment and adjustment of the shackles as required.

[REDACTED]

If the detainee is to be shackled standing with hands at or above the head (as part of a sleep deprivation protocol), the medical assessment should include a pre-check for anatomic factors that might influence how long the arms could be elevated.

[REDACTED]

Assuming no medical contraindications are found, extended periods (up to 48 hours) in a standing position can be approved if the hands are no higher than head level and weight is borne fully by the lower extremities.

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

Sleep deprivation

[REDACTED]

The standard approval for sleep deprivation, per se (without regard to shackling position) is 48 hours.

[REDACTED]

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[REDACTED]

The maximum time frame permitted under CTC policy for continued sleep deprivation is 180 hours.

[REDACTED]

[REDACTED]

NOTE: Examinations performed during periods of sleep deprivation should include the recording of current number of hours without sleep; and, if only a brief rest preceded this period, the specifics of the previous deprivation also should be recorded.

Cramped confinement (Confinement boxes)

Detainees can be placed in awkward boxes, specifically constructed for this purpose.

[REDACTED]

[REDACTED] These have not proved particularly effective, as they may become a safehaven offering a respite from interrogation.

[REDACTED]

[REDACTED] confinement in the

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small box is allowable up to 2 hours. Confinement in the large box is limited to 8 consecutive hours, up to a total of 18 hours a day.

Waterboard

This is by far the most traumatic of the enhanced interrogation techniques. The historical context here was limited knowledge of the use of the waterboard in SERE training (several hundred trainees experience it every year or two). In the SERE model the subject is immobilized on his back, and his forehead and eyes covered with a cloth. A stream of water is directed at the upper lip. Resistant subjects then have the cloth lowered to cover the nose and mouth, as the water continues to be applied, fully saturating the cloth, and precluding the passage of air. Relatively little water enters the mouth. The occlusion (which may be partial) lasts no more than 20 seconds. On removal of the cloth, the subject is immediately able to breathe, but continues to have water directed at the upper lip to prolong the effect. This process can continue for several minutes, and involve up to 15 canteen cups of water. Ostensibly the primary desired effect derives from the sense of suffocation resulting from the wet cloth temporarily occluding the nose and mouth, and psychological impact of the continued application of water after the cloth is removed. SERE trainees usually have only a single exposure to this technique, and never more than two; SERE trainers consider it their most effective technique, and deem it virtually irresistible in the training setting.

[REDACTED]

While SERE trainers believe that trainees are unable to maintain psychological resistance to the waterboard, our experience was otherwise. Some subjects unquestionably can withstand a large number of applications, with no immediately discernable cumulative impact beyond their strong aversion to the experience.

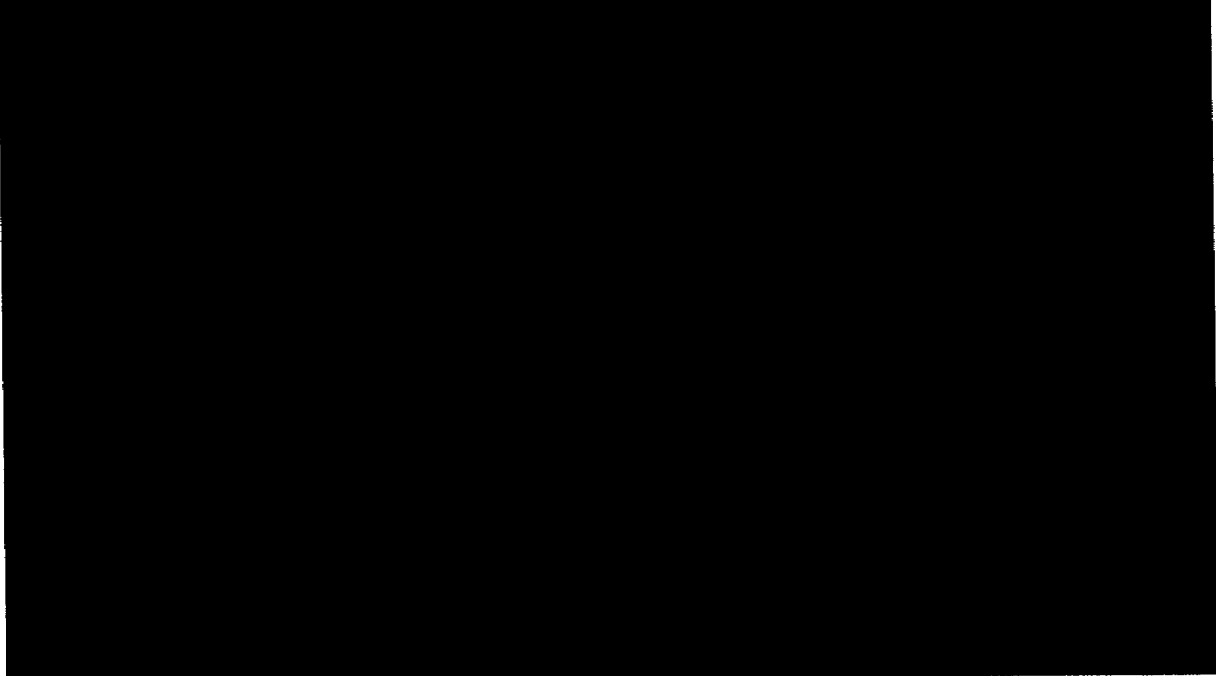
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The SERE training program has applied the waterboard technique (single exposure) to trainees for years, and reportedly there have been thousands of applications without significant or lasting medical complications. The procedure nonetheless carries some potential risks, particularly when repeated a large number of times or when applied to an individual less fit than a typical SERE trainee. Several medical dimensions need to be monitored to ensure the safety of the subject.



In our limited experience, extensive sustained use of the waterboard can introduce new risks. Most seriously, for reasons of physical fatigue or psychological resignation, the subject may simply give up, allowing excessive filling of the airways and loss of consciousness. An unresponsive subject should be righted immediately, and the interrogator should deliver a sub-xiphoid thrust to expel the water. If this fails to restore normal breathing, aggressive medical intervention is required. Any subject who has reached this degree of compromise is not considered an appropriate candidate for the waterboard, and the physician on the scene can not concur in further use of the waterboard without specific C/OMS consultation and approval.

A rigid guide to medically approved use of the waterboard in essentially healthy individuals 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 medical guidelines are based on very limited knowledge, drawn from very few subjects whose experience and response was quite varied. These represent only the medical guidelines; legal guidelines also are operative and may be more restrictive.

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A series (within a "session") of several relatively rapid waterboard applications is medically acceptable in all healthy subjects, so long as there is no indication of some emerging vulnerability [REDACTED]

Several such sessions per 24 hours have been employed without apparent medical complication. The exact number of sessions cannot be medically prescribed, and will depend on the response to each; however, all medical officers must be aware of the Agency policy on waterboard exposure. As of December 2004, CTC guidelines limit such sessions as follows:

"a. Approvals for use of the waterboard last for only 30 days. During that 30-day period, the waterboard may not be used on more than 5 days during that 30-day period.

b. The number of waterboard sessions during any given 24-hour period may not exceed two.

c. A waterboard "session" is the period of time in which a subject is strapped to the waterboard before being removed. It may involve multiple applications of water. A waterboard session may not last longer than two hours.

d. An "application" during a waterboard session is the time period in which water is poured on the cloth being held on the subject's face. Under the DCI interrogation guidelines, the time of total contact of water with the face will not exceed 40 seconds. The vast majority of applications are less than 40 seconds, many for fewer than 10 seconds. Individual applications lasting 10 seconds or longer will be limited to no more than six applications during any one waterboard session. The Agency will limit the aggregate of applications to no more than 12 minutes in any one 24-hour period."

By days 3-5 of an aggressive program, cumulative effects become a potential concern. Without any hard data to quantify either this risk or the advantages of this technique, we believe that beyond this point continued intense waterboard applications may not be medically appropriate. Continued aggressive use of the waterboard beyond this point should be reviewed by the HVT team in consultation with Headquarters prior to any further aggressive use. [REDACTED]

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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 used in the process (realizing that much splashes off), how exactly the 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.

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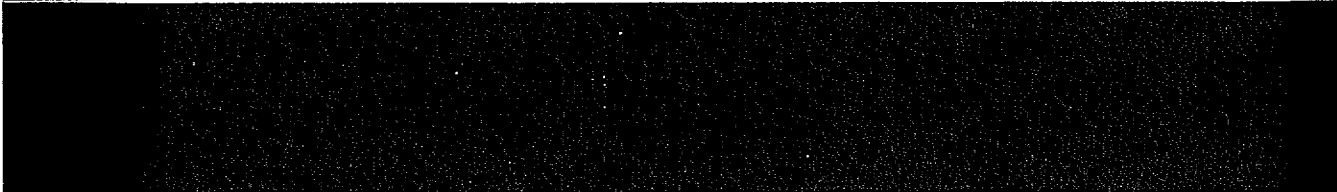
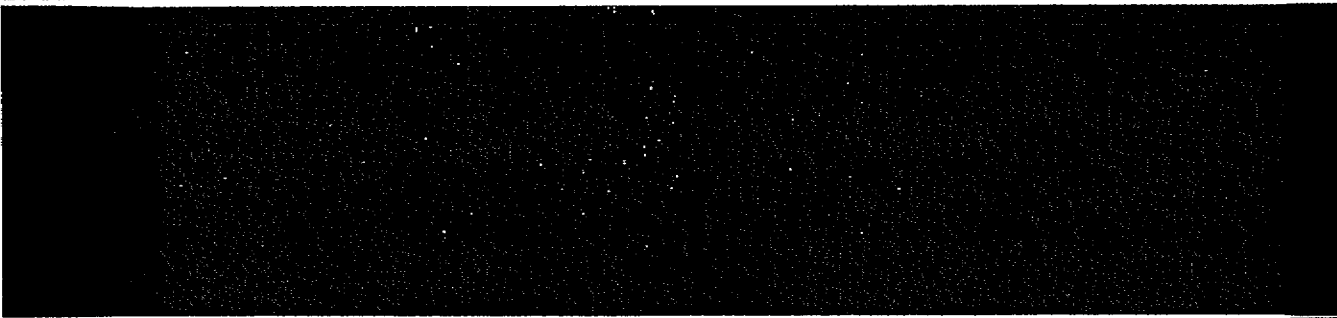

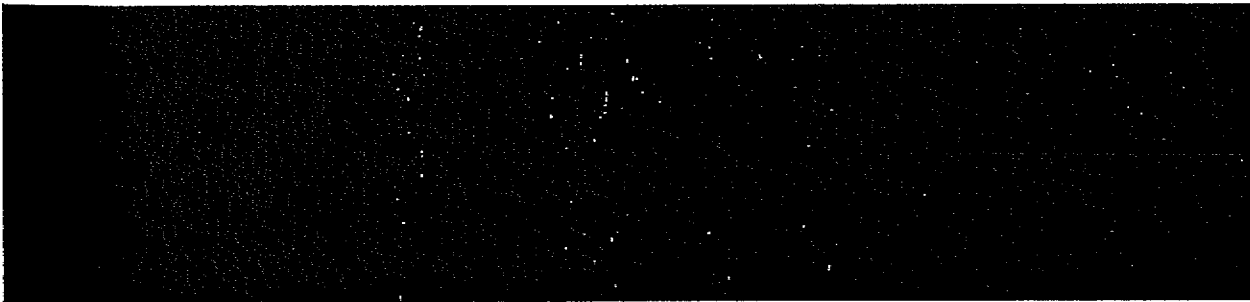
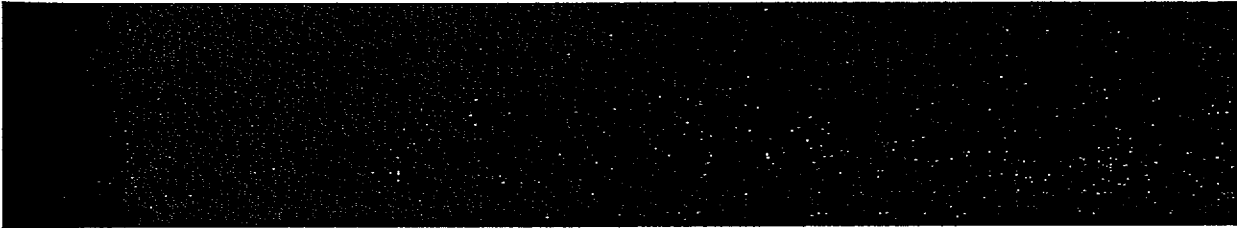
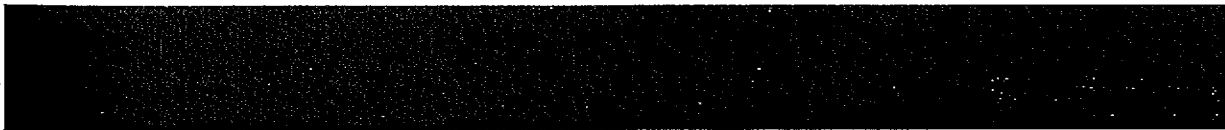

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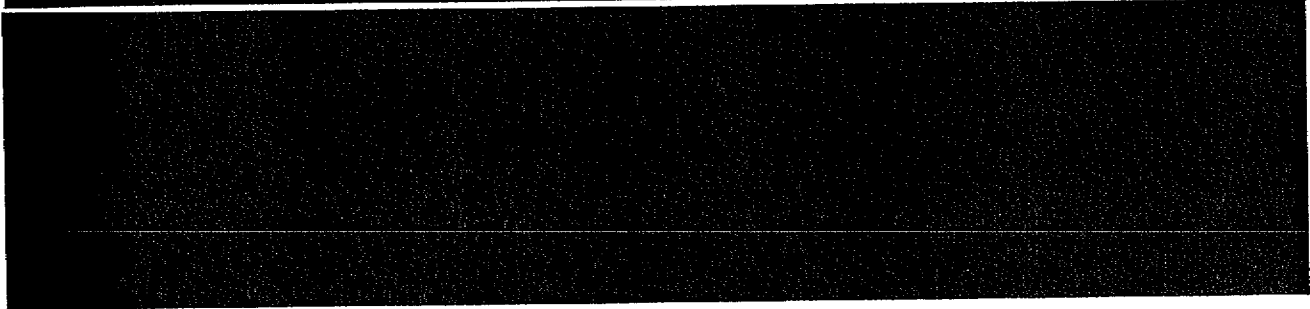
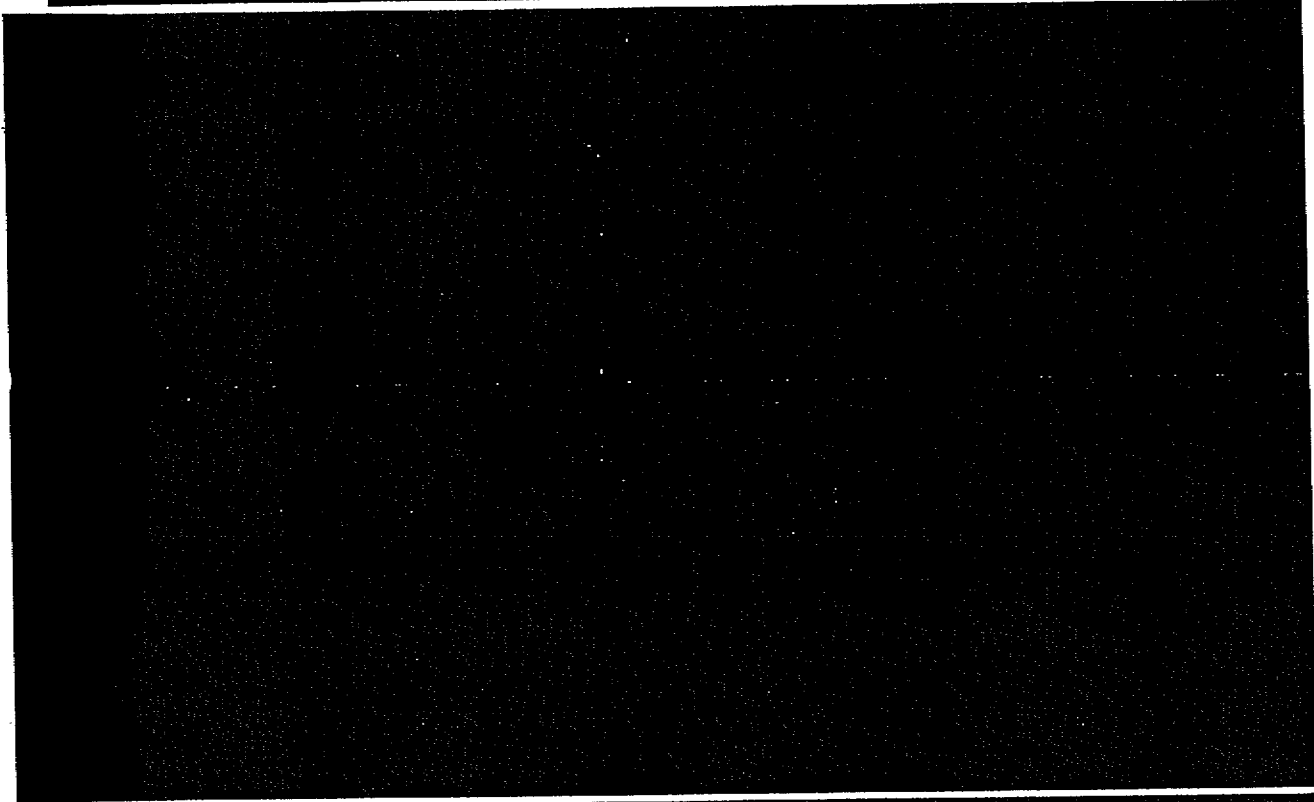
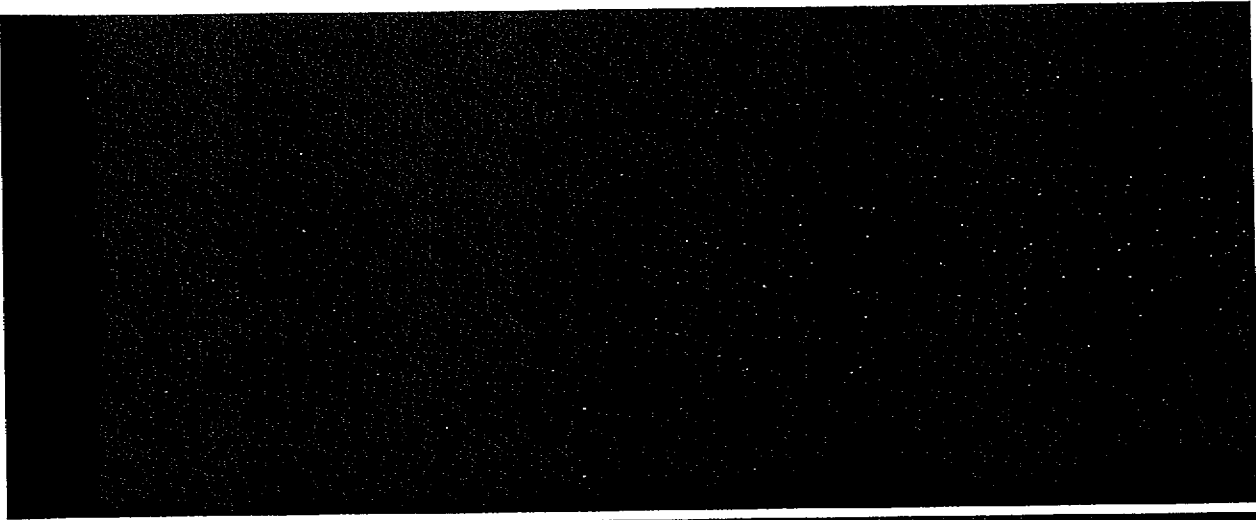
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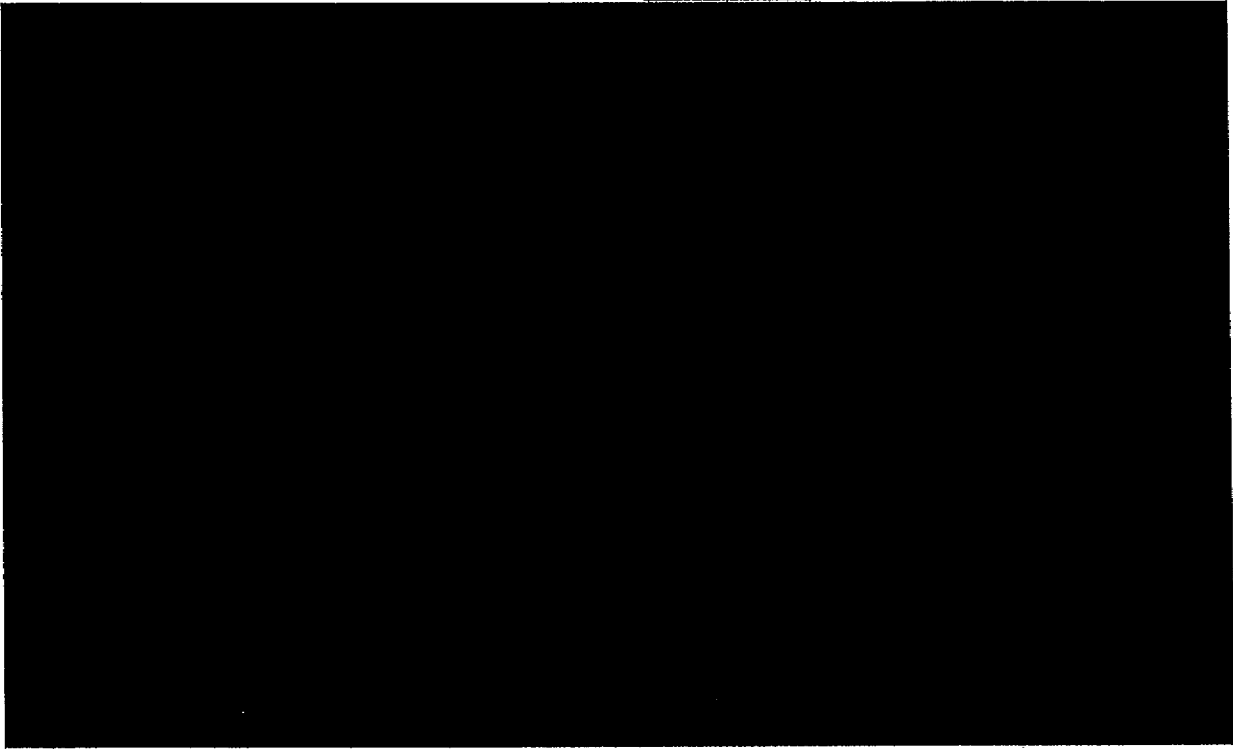
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General references: In addition to standard medical works, medical officers should refer to the Department of Justice Bureau of Prisons website at www.bop.gov, accessing "Central Office", then "Health Services" to view their clinical practice guidelines. These guidelines and policies are useful references for procedures in novel situations.

Other standard references which medical officers may find useful include "Standards for Health Services in Prisons", a regular publication of the National Commission on Correctional Health Care, last revised in 2003. *Clinical Practice in Correctional Medicine*, Michael Puisis, ed. Mosby Publishing, 1998, is a useful compendium of care for chronic and infectious health issues in the prison setting.

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Appendix A. Medical rationales for limitations on physical pressures

Measure	Medical Limitation	Rationale for Limitation	References
Shaving	None	Standard hygiene measure in other custodial settings; risk of skin infections	None
Stripping	Ambient air temperature at minimum 64 F/ 18 C	Below this temperature hypothermia may develop	WHO guidelines
Diapering	Evidence of loss of skin integrity due to contact with human waste materials	Diapering commonly employed in hospital and other care settings where incontinence is an issue.	None
Hooding	None; [REDACTED]	Methodology used in SERE training	[REDACTED]
Isolation	None	Methodology used in SERE, prison settings	[REDACTED]
White noise	79 dB max	Prevention of permanent hearing damage	OSHA guidelines for continuous noise exposure
Continuous light or darkness	Related to sleep deprivation	Used in other settings	[REDACTED]
Uncomfortably cool environment	<3 hours below 60 F / 16 C, with monitoring for development of hypothermia; use of water will further limit exposure time	Requires monitoring for development of hypothermia; risk is patient-specific	WHO guidelines; "Wilderness Medicine" 4 th Ed., Ch 6 - Accidental Hypothermia; Ch 9 Immersion into cold water
Restricted diet	Loss of 10% of	10% loss indicates	BOP guidelines

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Shackling in upright sitting or horizontal position Water dousing	body weight; or evidence of dehydration 48 hours standard; longer periods require medical monitoring Cessation upon evidence of hypothermia; ambient temperature minimum of 64 F / 18 C; potable water source	significant malnutrition and requires corrective action Prolonged standing likely to induce dependent edema, increase risk for DVT, cellulitis. Increased heat loss promoted by contact with water below 35 C; death can result from prolonged (i.e. 6 hour) exposure to 15 C water, 2 hrs at 10 C, 1 hr at 5 C; hypothermia can be induced in 30 minutes with 5 C / 41 F water, 45 minutes with 10 C / 54 F water, and 60 minutes with 15 C / 59 F water immersion. Immersion at temperatures below 25 C / 77 F will eventually be fatal over time. Periods of sleep deprivation of 90+ hours have been shown to be safe and without long term sequelae in large groups, and 200+ hours in individuals; required recuperative period undefined. Note 0.5 C drop in body temperature, which may impact use of water. Sleep deprivation does degrade cognitive performance, may induce visual disturbances, may reduce immune competence acutely.	CTC guidelines; experience with 20+ detainees "Wilderness Medicine" 4 th Ed., Ch 6 - Accidental Hypothermia; Ch 9 Immersion into cold water; Transport Canada, "Survival in Cold Waters", PREAL Operating Instructions CTC Guidelines; Horne, J. Why We Sleep NINDS/NIH web site
Sleep deprivation	48 hours for standard, [REDACTED]		

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Attention grasp	Correct technique; no preexisting injury likely to be aggravated	[REDACTED]	[REDACTED]
Facial hold	Correct technique; no preexisting injury likely to be aggravated	[REDACTED]	[REDACTED]
Insult slap	Correct technique; no preexisting injury likely to be aggravated	[REDACTED]	[REDACTED]
Abdominal slap	Correct technique; no preexisting injury likely to be aggravated	[REDACTED]	[REDACTED]
Stress positions	Correct technique; no preexisting injury likely to be aggravated	[REDACTED]	PREAL Operating Instructions
Walling	Correct technique; no preexisting injury likely to be aggravated	Risk of whiplash type injury, [REDACTED]	[REDACTED]
Cramped confinement	Correct technique; no preexisting injury likely to be aggravated	Attention to risks of immobilization, including DVT, and claustrophobia; ensure adequate air flow, ambient temperature	PREAL Operating Instructions
Waterboard	Correct technique; no preexisting injury likely to be aggravated; [REDACTED]	Risks include drowning or near drowning; hypothermia from water exposure; aspiration pneumonia, laryngospasm.	OMS Guidelines;
	resuscitation capability immediately at hand; potable water source		

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