Summary and Reflections of Chief of Medical Services on OMS Participation in the RDI Program

AL QA'IDA DETAINEES: the OMS Role

Press attention to the Agency's interrogation and detention program began with the 2002 capture of Abu Zubaydah, spanked again with the 2003 capture of Khalid Shaykh Muhammed, accelerated in 2004 in the wake of Abu Ghraib, and then exploded in 2005 following a number of significant leaks. By 2007 hundreds—perhaps thousands—of articles and editorials had been published on what arguably has become the most controversial program in Agency history. Viewed from within, the resulting public picture remains as much caricature as fact. If the past is any guide, however, this distorted picture will become the accepted public history of an important chapter in Agency history, with both present and future implications for those within the Office of Medical Services. These implications warrant a more informed internal account of how OMS understood and experienced this program at the time.[1]

[1] Of necessity, some broader program information is included in this chapter, to place the OMS role in perspective. Agency rendition. interrogation, and detention efforts were much more complicated than these glimpses suggest.

(b)(3) CIAAct
(b)(3) NatSecAct

The Context

(b)(1)
(b)(3) NatSecAct

September 11, 2001 began unremarkably. C/Medical Services arrived in [redacted] where OMS was providing temporary medical coverage, [redacted]

(b)(1)
(b)(3) NatSecAct

[redacted] Oddly, no one would answer the door at the station even though officers could be seen inside tightly gathered around a television. The World Trade Center's South Tower just had collapsed; a few minutes later the North Tower came down.[2] The Pentagon was hit. All were targets of hijacked commercial jetliners, so U.S. domestic flights were being ordered to ground and international flights turned away.

At Headquarters that Tuesday, [redacted] morning activities were sharply interrupted by news of these attacks. Ominously, a fourth hijacked plane was headed toward Washington. The Capitol and C.I.A. Headquarters were believed prime targets. With less then 30 minutes until ETA, an immediate evacuation of the buildings was announced, excepting (at CIA) emergency personnel such as those in medical. As the minutes passed, most emergency personnel relocated to below ground floors while [redacted] and a few others remained in the first floor clinical spaces.

(b)(3) CIAAct
(b)(6)

In retrospect, the Capitol appears to have been the final 9/11 target, though this was averted when passengers forced Flight 93 to crash in Pennsylvania. Nonetheless the events that day were the most galvanizing since Pearl Harbor. Within a week, the President signed a Memorandum of Notification (MON) [redacted] including "operations designed to capture and detain persons who pose a continuing, serious threat of violence or death to U.S. persons and interests or who are planning terrorist activities."[3]

(b)(1)
(b)(3) NatSecAct

The perpetrators of the 9/11 attacks were identified as al-Qa'ida terrorists, and there was immediate concern about a "follow-on" attack. As then DCI Tenet later recalled, "I've got reports of nuclear weapons in New York City, apartment buildings that are gonna be blown up, planes that are gonna fly into airports all over again, plot lines that I don't know. I don't know what's going on inside the United States, and I'm struggling to find out where the next disaster is going to occur. Everybody forgets one central context of what we lived through: the palpable fear that we felt on the basis of the fact that there was so much we did not know."[4] Lacking concrete intelligence, extensive lists of potential targets were drawn up, including the country's physical infrastructure (power plants, bridges, subway systems), symbolically important buildings, theme parks,

(b)(1)
(b)(3) NatSecAct [redacted]

[3] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 1. The MON was sighed 17 September 2001.
[4] "'60 MINUTES' -- Tenet Defends High Value Detainee Program," CBS News.com, 25 April 2007. Tenet laid out the context somewhat more fully in George Tenet, *At the Center of the Storm: My Years at the CIA* (New York City: HarperCollins, 2007), Chapter 13, pp. 229-258.

malls, and major forthcoming events such as the World Series (which was postponed a week), Super Bowl, and the Salt Lake City Winter Olympics.

While the possibility of a nuclear attack initially could not be ruled out,[5] the greatest emotion surrounded potential chemical or biological attacks. Anthrax was the single most likely biological threat, so OMS quickly acquired a large supply of ciprofloxacin (Cipro); and, in case of chemical attack, a stockpile of atropine auto-injectors.[6] OMS also arranged briefings on the Agency's best judgment on potential threats for senior medical personnel from State Department, NSA, FBI, HHS, the White House, and Congress, and compared emergency medical response plans.

In late October concerns elevated sharply when letters containing anthrax spores were delivered to Capitol Hill, fatally infecting some postal workers en route. Government agencies, including CIA, began specialized screening in their mail facilities and CIA was one of several to find trace amounts of anthrax. Given the tiny amount discovered, OMS judged that only a handful of potentially exposed employees needed to be offered Cipro prophylaxis, but DCI Tenet announced it would be made available to any concerned employee. Emergency distribution was arranged for the following day—a Saturday—and involved most of the OMS headquarters staff. Several hundred anxious Agency employees came in for individual evaluations and counseling, and were issued medication. Tenet visited during this operation and mentioned to C/MS that he thought it "a slam dunk" that al-Qa'ida was behind this attack.

Anthrax-contaminated mail also passed through a State Department distribution center, potentially contaminating outgoing diplomatic pouches. This threat, combined with the incidental "dust" found in old pouches and hoax powders mailed to many embassies, spawned local crises around the world

(b)(1)
(b)(3) NatSecAct

At Agency headquarters, all incoming mail was halted until a method for decontamination could be identified. OMS's Environmental Safety Group took the lead in this project and soon was directly running a heat-based treatment program for all incoming mail. OMS also was at the forefront of an effort to identify suitable perimeter, portal and building CBRN screening devices, which eventually led to an extensive headquarters monitoring program.

Later analysis concluded that the October anthrax attack probably was the work of a disgruntled domestic scientist, rather than international terrorists; and that all detected anthrax could be traced back to distribution centers contaminated by leakage from the

[5] Maps, probably dating from the 1950s, were provided to OMS outlining the potential effects of a weapon detonated on the Mall

[6] Some auto-injectors were issued to the Security Protective Officers, believed most likely to be exposed to a chemical attack. The only actual use of an auto-injector came when an officer inadvertently discharged one into his own leg, thinking it was a demonstration dummy.

two spore-containing letters mailed to Capitol Hill. Nonetheless, the extensive press coverage highlighted U.S. vulnerability to this type of attack and the high cost of responding.

Concurrent with these developments and with the Presidential MON in hand, the Agency moved aggressively abroad. Intense efforts were mounted jointly with foreign intelligence services to round up al-Qa'ida operatives worldwide.

(b)(1)
(b)(3) NatSecAct

Over the next five years, OMS PAs or physicians accompanied at least 120 of these rendition flights—most either to or between newly established CIA facilities.[7]

The pre-rendition medical exam included a body cavity search (a component of which was a rectal exam), which in later years led to an occasional charge that CIA administered drugs rectally during the rendition process. The PA (or occasionally an OMS physician) did carry medical supplies for emergency use, but only once was a dangerously agitated detainee sedated during flight.[8] Eventually a few of those being transferred—mostly long-term detainees—were medicated voluntarily for conventional medical reasons (e.g., one requested a sleeping pill for the flight). No one ever was medicated rectally.

At the time of the 9/11 attacks the Taliban government of Afghanistan was hosting the al-Qa'ida leadership, its training camps, and several potential chemical/ biological/radiological/nuclear sites. In mid-October 2001 (concurrent with the anthrax scare) the U.S. launched a combined attack against the Taliban. The offensive brought together small independently operating joint CIA-Special Forces teams (which included

(b)(1)
(b)(3) NatSecAct

OMS PA's),

and U.S. air power. By mid-December all major Afghan cities had been taken.[9]

A week after the last major Afghan city fell, al-Qa'ida "shoe bomber" Richard Reid attempted to blow up a commercial jet en route from Paris to Miami. A month later *Wall Street Journal* reporter Daniel Pearl was kidnapped in Karachi and demands were issued by his captors; a few weeks later his decapitated, dismembered body was found,

(b)(1)
(b)(3) NatSecAct

[8] Valium was administered on flight

(b)(1)
(b)(3) NatSecAct

and a week after that a video of his execution was released. Although more than 2,900 al-Qa'ida operatives and associates were in custody, in 90 countries, [10] only one senior al-Qa'ida leader (Atef) had been killed (by an airstrike in November), and none had been captured. The U.S. remained braced for the next terrorist attack.

In March 2002 the newly created Department of Homeland Security established color-codes to quantify the estimated level of threat. These ranged from green (low), through blue (guarded), yellow (elevated), orange (high), to red (severe). With little hard intelligence, these levels were based largely on unconfirmed reports, non-specific terrorist "chatter," and intelligence supposition. The first announced level that March was yellow, or "elevated."

[10] The first 20 military detainees to be sent to Guantánamo Bay arrived at Camp X-ray, on January 11, 2002; by the end of February about 300 had arrived, and by the end of the year, over 600.

Saving the life of a High Value Target (HVT)

Against this backdrop the Counter-terrorism Center (CTC) Rendition Group (RG, later Rendition and Detention Group, or RDG) came to the OMS front office late Friday morning, March 29, to say that very early the previous morning (March 28th), senior al-Qa'ida leader Abu Zubaydah ("AZ") had been captured in Faisalabad, Pakistan. Zubaydah was thought to rank third or fourth in the al-Qa'ida hierarchy, to have been "involved in every major [al-Qa'ida] terrorist operation," and to have information on immediate future threats.[11] Anticipating his capture, a rendition aircraft already was standing by with an OMS PA on board. For the first time, the Agency was to retain custody of a terrorist, and AZ was to be taken to an Agency facility where he could be questioned by Agency (and FBI) interrogators. However, Zubaydah had been wounded during capture and would need sophisticated medical care.[12] Could OMS handle an emergency surgical mission? OMS said yes, and began to line up the requisite personnel and equipment.

(b)(1) (b)(3) NatSecAct (b)(3) CIAAct (b)(6)

By noon, RG was back to say that Zubaydah was to be flown to where a holding cell was hurriedly being set up A plan was quickly worked out for our RMO (then on temporary assignment to fly and join the rendition crew. As soon as Zubaydah could be moved, this group would pick him up, and fly A larger medical team, composed of a trauma surgeon, anesthetist, and two PA's, along with other CTC personnel and necessary medical and surgical equipment, would leave Washington that evening to receive AZ with just 5 hours to assemble staff and equipment before departure.

(b)(1) (b)(3) NatSecAct

Our preferred surgeon—a cleared contractor long associated with OMS He agreed to drive directly back and to recruit anesthetist. The two selected PA's included one visiting Headquarters and a surgically experienced recent hire Field Operations and Nursing staffs quickly assembled the necessary equipment by stripping the OMS emergency room and obtaining the donation of surgical equipment—no questions asked—from Hospitals. Absent time to

(b)(1) (b)(3) CIAAct (b)(3) NatSecAct (b)(6)

(b)(1) (b)(3) NatSecAct

[11] In a brief to the Department of Justice a few months later, AZ was described as al-Qa'ida's coordinator of external contacts and foreign communications, its counterintelligence officer, and to have been involved to some extent in Millennium plots against U.S. and Israeli targets, and a 2001 Paris Embassy plot, as well as the September 11 attacks.

[12] U.S. military medical facilities were not considered an option as the resulting public exposure would greatly reduce AZ's value as an intelligence source

[13] Regional coverage during this period was a challenge; (b)(1) (b)(3) NatSecAct

(b)(1) (b)(3) CIAAct (b)(3) NatSecAct (b)(6)

return home, the PAs went to a local mall to buy suitcases and clothes. who joined the team at the airport where the senior PA took him to phone booth and had him sign a secrecy agreement. Twenty-four hours later the team was setting up at

AZ had been shot from the ground while attempting to escape along a rooftop. Initially reported to have been hit three times, his wounds were the result of a single bullet which entered his left leg anteriorly just above the knee, passed deeply through muscle tissue and exited anteriorly in the upper thigh, then reentered the lower abdomen. Fragments ended up embedded in the posterior abdominal wall. surgeon (b)(1) done an exploratory laparotomy, repaired some bowel damage, administered seve (b)(3) NatSecAct of blood, and left behind the less accessible fragments; the leg wounds received only superficial attention.

(b)(1) (b)(3) NatSecAct

On March an FBI EMT present for the Zubaydah takedown advised that although AZ remained "septic" in appearance, his vital signs were "normal" and he was "stable for travel." RMO joined the team and the rendition flight immediately departed AZ was collected (b)(1) and the flight continued (b)(3) NatSecAct During the flight AZ was agitated, and his breathing somewhat labored, so small doses of Valium were administered to allow him to rest. Having safely delivered AZ to the facility, the (b)(1) RMO then continued on with the rendition team then back to his post. (b)(3) NatSecAct

(b)(1) (b)(3) NatSecAct

On evaluation at AZ was found to have a small entrance wound in his lower thigh, a large, fist-sized exit wound in his groin, and a recently sutured xyphoid-to-pubis laparatomy with abdominal drain. Of most immediate concern was his labored breathing and a developing fever. Despite adjustments to his antibiotic coverage, AZ's condition deteriorated over the next 36-hours to a full-blown Acute Respiratory Distress Syndrome (ARDS), accompanied by a racing pulse, falling blood pressure, fever of 104°F, and evacuating bowels. An emergency intubation was performed, and while being manually ventilated AZ was transported to the intensive care unit

(b)(1) (b)(3) NatSecAct

At the hospital, AZ was placed on a respirator, and (b)(1) surgeon joined the team.[14] (b)(3) NatSecAct

On April 1st, about the time of AZ's ARDS crisis, the White House announced his capture, including the fact that he was receiving medical care for gunshot wounds in the "thigh," "groin" and "stomach." By April 2nd, there was extensive press coverage, informed by official Pentagon news conferences and alleged inside sources. Questions were raised about where and how AZ was being treated. Defense Secretary Rumsfeld—

[14] A (b)(1) (b)(3) NatSecAct pulmonologist also was summoned, but offered only a limited-value, one-time consult.

presumably unaware of recent events—informed reporters that AZ's "wounds appear not to be life threatening" and that he was "being given exactly the excellent medical care one would want if they wanted to make sure he was around a good long time to visit with us."[15] Nothing was said about location.

During the initial period of hospitalization, AZ suffered from pulmonary congestion, an atonic colon, a marked drop in his platelet count (to 32,000), fever, and an emerging bullet tract infection. After an adjustment to his antibiotic coverage, and a surgical exposure and antiseptic irrigation of the length of the bullet track (by the contract surgeon), he began to improve, with rising platelet count, some clearing of the lungs, and less sustained fever.[16] Nonetheless, as a precaution, [redacted] intensivist was requested to travel to site, against the possibility of further complications.

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct
(b)(6)

As during most crises, the demand for information was unending, and in this case extended to the White House. Accordingly, on-site medical personnel, in addition to providing a 24-hour hospital presence, responded to many e-mails and phone calls, and from April 2nd onward prepared a detailed, 12-hourly cable update (at 2:00 a.m. and 2:00 p.m. locally) to allow the DCI to make timely reports. These cable reports were prepared primarily by [redacted] RMO, just arrived to monitor AZ's progress. With the RMO's arrival, and inpatient care now primarily in the hands of the [redacted] surgeon, the OMS contract surgeon and anesthetist were able to depart.

(b)(1)
(b)(3) NatSecAct

Although showing slow overall improvement, AZ's hospital course was not without complication. On the morning of April 4th, he coughed up his respirator tube, then proved too weak to breath on his own, and was reintubated. Fortuitously, the [redacted] intensivist [redacted] oversaw further pulmonary care. Three days later—a week after his hospitalization—AZ was safely weaned from the respirator. Meanwhile, on April 6th a fever had returned, apparently triggered by a deterioration of his leg wound. On three consecutive days (April 6-8), [redacted] surgeon (assisted by an OMS PA) debrided necrotic tissue from the wound, which ultimately left the bullet tract clean but widely laid open along its entire length. A final debridement was accomplished two days later.

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct
(b)(6)

(b)(1)
(b)(3) NatSecAct

As AZ's leg infection and respiratory problems came under control, new concerns presented. A rising amylase, worsening liver function tests, and a falling hemoglobin (never definitively explained) led to the discovery of an intra-abdominal inflammatory mass near the site of a bullet fragment. Reluctantly, an exploratory laparotomy was considered, but fortunately proved unnecessary. An endophthalmitis also developed in AZ's left eye, which had been opacified at the time he came into Agency hands. [redacted] ophthalmologist recommended urgent enucleation, to avoid

(b)(1)
(b)(3) NatSecAct

[15] E.g., *Los Angeles Times* and *New York Times*, both 3 April 2002.
[16] The present account is not meant to be a detailed medical history; the few specifics given here are intended only to give a general sense of the case.

involvement of the good eye. OMS, in consultation with cleared Washington-area specialists, opted rather for antibiotics and culture (which proved negative). This inflammation soon resolved, and eventually the left orbit atrophied without further complication.

These proved to be the last of AZ's medical crises, and with his continued improvement, the intensivist departed. On April 12th he was moved from the ICU to a VIP suite, afebrile, pain-free, on a full diet, with a leg wound now healthy in appearance, and able to get up and down on his own. Medical concerns were now replaced by operational concerns. [redacted] Now, despite a 24-hour Agency bedside presence, AZ was potentially able to speak t[redacted] staff, which could reveal his identity and thus whereabouts.

(b)(1)
(b)(3) NatSecAct
(b)(1)
(b)(3) NatSecAct

On April 15th, after just three days in the private suite, but two weeks after his admission and nineteen days since his gunshot wound, AZ was transferred back to [redacted][7] A headquarters-based physician, ER-qualified nurse, and new PA arrived to take over care. By month's end, a continuous physician and PA presence no longer were needed, and for the next three months AZ's day-to-day care was provided by TDY OMS nurses who administered twice daily, and then daily, wound care and dressing changes. For the first phase of exclusively nurse coverage, [redacted] RMO made weekly two-day return visits, but things went so smoothly that these eventually were discontinued.

(b)(1)
(b)(3) NatSecAct

With his leg wound visibly healing, AZ's primary medical concern was a mild prostatitis (manifest only by a trace of blood in his semen), which he feared was the first sign of an impending loss of "manhood." He also was inclined to focus on other minor complaints—especially during periods of interrogation—including some knee discomfort, intestinal gas pains, and a mild reflux esophagitis. Basically, however, he was a healthy young man given to some hypochrondriasis.

[17] Versed and morphine were given to ease the transfer.

Embracing SERE (Survival, Evasion, Resistance, Escape]

The circumstances of AZ's capture had not lessened the urgency felt to question him about a "second wave" of al-Qa'ida attacks. Later press reports claimed that not only did his injuries not delay this questioning, but that his acute pain was exploited. The most detailed version of this myth had Agency doctors installing an IV drip through which a short-acting narcotic painkiller was switched on and off, depending on Zubaydah's degree of cooperation.[18] In actual fact, AZ was not interrogated during the painful phase of his injuries (for much of which he was on a respirator), or at any point while he was in the hospital. At no time then or later were medications of any sort withheld.

The interrogation approach initially taken with AZ was relatively conventional. Within the limits of his medical condition, these involved a combination of positive and negative incentives, with the expectation that modest pressures would be necessary to weaken his psychological defenses. Permission to use a few non-physical but mildly aggressive techniques, if necessary, had been granted just prior to his return from the hospital [redacted] These included an austere cell, limited clothing, sleep deprivation, bright lights, white noise, and dietary manipulation (i.e., a nutritionally adequate diet of Ensure supplemented with vitamins). Under the circumstances, "positive" incentives would be the return of withdrawn amenities, such as the return of full clothing, a more comfortable chair or sleeping arrangement, and a more interesting diet.

(b)(1)
(b)(3) NatSecAct

This basic approach, OMS learned, was drawn mostly from the military's SERE (Survival, Evasion, Resistance, Escape) training program. With antecedents dating to the Korean War, SERE was designed to prepare military personnel for capture by familiarizing them with how they might react to various interrogation techniques, and offer some coping skills. It was the only extant U.S. program to subject personnel to physical interrogation measures.[19]

At one time OMS psychologists, psychiatrists, and medics were extensively involved in a SERE-like Agency program also designed to prepare employees—initially U-2 pilots—against the possibility of capture and interrogation. OMS staffers assessed candidates, monitored participants, and even served as instructors in this program [redacted]

(b)(1)
(b)(3) NatSecAct

[18] Gerald Posner, *Why America Slept: The Failure to Prevent 9/11* (New York: Random House, 2003, pp. 184-186.

[19] During the Korean War, many American POWs collaborated to some extent with their captors. This was believed the result of interrogation techniques, which might have been resisted more effectively had previous training been available. As a result, by the mid-1950s several SERE-like training programs had been developed and implemented. When the SERE antecedents of the Agency program finally were widely publicized, particularly in 2007, it was popular to say that SERE techniques had been "reverse engineered" to produce the Agency (and military) interrogation techniques. No reverse engineering was needed, however; the interrogation techniques used on SERE trainees were simply used on detainees.

(b)(1) (b)(3) NatSecAct [redacted]

(b)(3) NatSecAct [redacted]

The Agency's "Risk of Capture" and "Enduring Enemy Detention" training was much less physical than SERE training (discussed more fully below), but did include sleep deprivation and confinement in a narrow, upright box (another SERE technique). The perceived need for this program dwindled in the 1980s, and it finally was terminated in the early Nineties. A few OMS staffers still on-board in 2002 had supported this program, but none were familiar with the current SERE experience, nor its more physical techniques.

The Agency office with the greatest current SERE familiarity was the Office of Technical Services (OTS), in which were located a unit of operationally-oriented psychologists whose interests in interrogation extended back almost fifty years.[20] While Agency involvement in interrogations programs had all but disappeared after the mid-1980s, a SERE-trained psychologist had joined the OTS staff in 1999 and through him OTS was acquainted with the current SERE program and some of its psychologists.

In the immediate wake of 9/11 OTS again returned to the subject of interrogation and that September contracted with recently retired Air Force SERE psychologist Jim Mitchell to produce a paper on al-Qa'ida resistance-to-interrogation techniques. Mitchell collaborated with another Air Force SERE psychologist, Bruce Jessen, and eventually produced "Recognizing and Developing Countermeasures to Al-Qa'ida Resistance to Interrogation Techniques: A Resistance Training Perspective."[21] Following AZ's capture, Mitchell was sent to [redacted] to serve as a behind-the-scenes consultant to interrogators and the on-site OTS staff psychologist (who was there to evaluate AZ psychologically, and explore possible approaches to interrogation and debriefing.)

(b)(1) (b)(3) NatSecAct

Under most circumstances, interrogators seek to exploit the initial shock of capture, which in AZ's case was long since past. In lieu of this they chose to take advantage of the "shock" of his return to detainee prisoner status, in the austerity of a [redacted] cell. One day after his return from the comfortable hospital setting, a three day period of interrogation was begun, employing all the previously approved measures. The on-site OMS physician monitored this closely, and found that neither the initial three-day period of sleep deprivation nor shorter periods repeated several days later that week impacted his continuing recovery. These measures also failed to garner any

(b)(1) (b)(3) NatSecAct

[20] The antecedents of this unit had overseen much of the MKULTRA interrogation research in the 1950s and 1960s, published still-relevant classified papers on the merits of various interrogation techniques, contributed heavily to a 1963 KUBARK Counterintelligence Interrogation Manual and its derivative 1983 Human Resources Manual, assisted directly in early interrogations, and (with OMS) provided instruction in the Agency's Risk of Capture training. Bureaucratic tensions between OMS and OTS (and their antecedent offices) extended across 50 years, and again were at a peak in 2002. While concurrent questions of organizational charter, expertise, and placement color much of the OMS detainee experience, this complicated issued is beyond the scope of this history.

[21] Mitchell had 13 years of experience in the Air Force SERE program, and Jessen 19 years. Additionally, Jessen had worked with released U.S. military detainees in the Nineties.

dramatic new intelligence. A one day repetition the following week was similarly ineffectual. As the on-site personnel assessed the situation, "there is unlikely to be a 'Perry Mason' moment where the subject ultimately gives up but rather will likely yield information slowly over the course of the interrogations. The subject currently is taking a highly sophisticated counter-interrogation resistance posture where his primary position is to avoid giving details."[22]

The next contemplated step—which was approved for use at the end of AZ's first week of interrogation—would have been more punitive: placing him in a "confinement" box akin to that previously used in the Agency's own training program. As OMS was advised, confinement boxes had been introduced into SERE after POW's in Southeast Asia reported being placed in small, uncomfortable boxes.[23] About 60% of the POWs so treated said it led to their cooperation with interrogators. The proposed Agency box was to be 30" x 20" x 85", which was more spacious than both the "prototype" SERE box and the one once used in Agency training. The plan was to confine AZ in a reclining box for a trial period of 1-2 hours, repeated no more than 3 times a day, similar to initial SERE usage. [redacted] believed that it would "achieve the desired effect."

(b)(1)
(b)(3) NatSecAct

OMS, concerned that AZ might accidentally or deliberately injure or contaminate his wound in the box, specified that he not be placed on his abdomen and that there be audio and infrared monitoring equipment (the latter already planned by CTC). Ultimately, use of the box was deferred so that FBI interrogators could attempt to make a deal in which, in exchange for cooperation, AZ would not be turned over to Middle Eastern countries seeking his custody. This, too, failed to gain the desired cooperation. However, rather than simply return to the planned use of the confinement box, a more systematic strategy now was developed.

(b)(1)
(b)(3) NatSecAct

[22] [redacted] 20 April 2002 SECRET. At some early point AZ, apparently inadvertently, did give up information that led to the capture in Chicago of Jose Padilla. Padilla was planning a "dirty bomb" attack against Washington, D.C. or New York. Most of what AZ provided were guesses as to what might constitute a future target. At this time the first of what later became a steady stream of leaks was reflected in a ABC World News Tonight report that AZ "has told U.S. interrogators al Qaeda plans to attack areas where large numbers of people shop. ...And privately, some U.S. officials fear Zubaydah is toying with them, trying to deplete already stretched U.S. resources. One official tells ABC News it's going to take a long time, if ever, to break Abu Zubaydah." ABC World News Tonight ABC TV, 23 April 2002, "Abu Zubaydah Warns U.S. Investigators."

[23] Both large and small boxes actually trace to a Russian usage in World War II. "The smallest type of cell...was actually a box measuring a meter in each dimension into which the prisoner was crammed in a sitting position. A large electric bulb in the ceiling provided an excess of light and heat, and after ten to twenty hours the prisoner lost consciousness. After being revived with a bucket of icy water, he would be interrogated immediately... A similar type of cell was aptly named the 'standing coffin.' It consisted of a box about a half-meter in depth, a meter wide, and two meters high in which a prisoner could neither sit nor lie down. Sometimes the standing-coffin was a full meter in depth and the prisoner could squat on the floor; at other times the ceiling was so low that the prisoner could at no time stand fully upright." Kermit G. Stewart, *Russian Methods of Interrogating Captured Personnel*, World War II (Office of the Chief of Military History, Department of the Army, 1951), p. 316

With AZ's continued recovery, and no immediate plans for intensive interrogation, the headquarters physician and PA departed. During the follow-on (b)(1) (b)(3) NatSecAct RMO visits, consideration was given to whether a skin graft would accelerate the healing of the leg wound. It was judged that that, given the depth of the wound, this would have to wait. Assuming it could be arranged locally, this entirely elective procedure would have to be timed so that the recovery period did not impede any ongoing interrogation. As circumstances developed, no graft was seen as necessary; by the time the wound had granulated in sufficiently, it was well on the way to complete healing.

In mid-June, AZ was informed that as a result of his failure to cooperate the sympathetic interrogation team then present was being withdrawn and that he was to be left in isolation to reconsider cooperating before a much more aggressive team arrived. Then, for almost two months he was left in the hands of "indifferent" guards who fed him at irregular hours and only once a day (albeit with sufficient nutrients for a full day). An OMS medical attendant continued to dress his wound, although at less frequent intervals, averaging about every two days. Wound healing was carefully monitored throughout, and continued its steady improvement.

Given the lack of success with AZ, SERE psychologists Mitchell and Jessen (the latter having retired from the Air Force in May and became an OTS IC) were tasked with devising a more aggressive approach to interrogation. Their solution was to employ the full range of SERE techniques. They, together with other OTS psychologists, researched these techniques, soliciting information on effectiveness and harmful after effects from various psychologists, psychiatrists, academics, and the Joint Personnel Recovery Agency (JPRA), which oversaw military SERE programs.

As later categorized by Mitchell and Jessen, the pressures to which SERE-trainees are subjected during a three-day "captivity" fall into three general categories. *Conditioning* techniques weaken psychological defenses and deprive the students of their usual sense of personal control. These include such things as stripping, diapering, sleep deprivation, dietary restriction, and solitary confinement; as noted, these measures also provide an opportunity for positive rewards for cooperation. *Corrective* techniques are physically punitive, and are designed to sharply disabuse a trainee of the notion that they won't be touched and focus them on the interrogators and the questions being asked. These include "attention" holds of the face, "attention" slaps to the abdomen and face, and slamming the student against a wall ("walling"). *Coercive* techniques are the most aggressive of the negative measures, and are designed to accelerate the trainee's entrance into full compliance. These can include placement in stressful positions, confinement in boxes, dousing with water, immersion in cold ponds, and exposure to the "waterboard" (which invokes a sense of drowning through the application of water to a cloth-covering the nose and mouth of a supine subject). At the extreme some SERE programs even used mock burials.

Despite the physical and psychological intensity of the SERE program, thousands of trainees had completed the course without physical or psychological aftereffects. In part this is because SERE candidates (and instructors) are medically and psychologically prescreened, and physicians and psychologists monitored the entire process. All measures, even the most aggressive, are designed and administered to insure the safety of those interrogated. "Slaps" are open-handed, short-arc, and directed at narrowly-circumscribed "safe" areas; those "walled" are supported with a rolled towel around the neck, and the blows directed against flexible walls designed to absorb the blow while amplifying the sound; water immersion is limited by ambient air and water temperature; and water-board applications generally are limited to 20 seconds, and no more than 40 seconds.

By early July a specific plan for the aggressive phase of AZ's interrogation had been worked out. The goal was to jarringly "dislocate" his expectations of treatment, and thereby motivate him to cooperate. (At the time AZ was believed to be author of the al-Qa'ida manual on interrogation resistance; he still seemed to think if he could hold out longer, he would be transferred into the benign U.S. judicial system.) The interrogations would be handled exclusively by the two contract SERE psychologists,[24] who would escalate quickly through a "menu" of pre-approved techniques. These were to be "the same techniques used on U.S. military personnel during SERE training" (detailed above), designed for maximum psychological impact without causing "severe physical harm."[25] A medical person with SERE experience—i.e., a senior OMS PA, who had worked in the previous Agency program—was to be present throughout and, when warranted, an OMS physician. The OMS medical officers' exclusive role was to assure AZ's safety during interrogation.

As a practical matter, and with OMS concurrence, there were to be two sizes of confinement boxes. Confinement in the previously described larger box would be limited to 8 hours (and no more than 18 hours total in a 24 hour period). A much smaller box also would be built, measuring 30" high x 21"x 30". Confinement in this box would be

[24] CTC described Jessen as a "SERE interrogation specialist" experienced "in the techniques of confrontational interrogations."

[25] Alfred McCoy, a professor of history of some note later claimed in *A Question of Torture* (REF) that the CIA approach to interrogation reflected an internal program extending back to the 1950s. Agency interest in interrogation did begin very early, and continued into the early Eighties, but was not a direct antecedent of the 2002 CTC approach, which came directly from Jessen and Mitchell's SERE experience. Both SERE and initial Agency thinking, however, drew on the same early Agency and military-funded studies. The early research was summarized in Albert D. Biderman and Herbert Zimmer, eds., *The Manipulation of Human Behavior* (New York, Wiley & Sons, 1961), with which Jessen and Mitchell were familiar. Their conceptual framework relied heavily on the Biderman chapter by Lawrence Hinkle on "The physiological state of the interrogation subject as it affects brain function." Both Biderman and Hinkle had received MKULTRA support. For McCoy's perspective, see Alfred W. McKoy, *A Question of Torture: CIA Interrogation, from the Cold War to the War on Terror* (New York: Metropolitan Books/Henry Holt and Co., 2006). McCoy occupies a named chair at the University of Wisconsin-Madison.

limited to two hours.[26] Care was to be taken not to force AZ's legs into a position that would compromise wound healing. In actual practice, the larger box was used in an upright position, through its dimensions were such that AZ (who was quite flexible), could sit down if he chose, albeit in a cramped position; even the small box accommodated a squatting position sometimes adopted by AZ on his own volition. At the planned point of peak interrogational intensity, waterboard applications would be alternated with use of the confinement boxes (in which he would "contemplate his situation") until, it was hoped, "fear and despair" led to cooperation.[27]

OTS psychologists prepared briefing papers to accompany an Agency request to DoJ seeking an opinion on whether the SERE-techniques could legally be used in an actual interrogation. Of the possible measures, only the waterboard and mock burial were believed by the Agency's Office of General Counsel (OGC) to require prior Department of Justice (DoJ) approval. However, ten "Enhanced Interrogation Techniques" (EITs) initially were proposed: attention grasp, walling technique, facial hold, facial or insult slap, cramped confinement boxes, wall standing, stress positions, sleep deprivation, waterboard ("historically the most effective technique used by the U.S. military"), and mock burials. To these was added the placement of harmless insects in the confinement box (based on AZ's apparent discomfort with insects). After preliminary discussion with the Department of Justice, mock burial had been eliminated from consideration. Of specific interest was whether any of these measures were barred by the most relevant Federal torture statute which prohibited the intentional infliction of severe physical or mental pain or suffering.[28]

Among the items forwarded to DoJ along with the request was a 24 July 2002 OTS paper on "Psychological Terms Employed in the Statutory Prohibition on Torture," a memorandum from the Air Force Chief of Psychology Services, Major Jerald Ogrisseg, on the Air Force experience with SERE, and an OTS-prepared AZ psychological assessment. According to Ogrisseg, almost 27,000 students had undergone Air Force SERE training between 1992 and 2001, of which only 0.14% had been pulled for psychological reasons (and of which none were known to have had "any long-term psychological impact"). The OTS paper assessed the relative risk of the various techniques, and concluded that while they had been administered to volunteers "in a harmless way, with no measurable impact on the psyche of the volunteer, we do not believe we can assure the same for a man…forced through these processes…. The

(b)(1)
(b)(3) NatSecAct

[6] This small box was not much smaller than boxes occasionally used in Agency exfiltrations a decade and more earlier.

(b)(1)
(b)(3) NatSecAct

[27] The quotations in this and the preceding paragraph are from an outgoing cable, from ALEC to [redacted] 9 July 2002, outlining the proposed plan. The CTC/Legal analysis was presented to the Legal Adviser to the NSC, and the DOJ Office of Legal Counsel, and Criminal Division; it also was briefed to the Counsel to the President. See CTC/Legal to [redacted] 25 July 2007.

[28] A DOJ review of the use of mock burials would have been much more time-consuming than what was needed for the other measures. Some of this history is found in Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, pp. 13-15.

(b)(1)
(b)(3) NatSecAct

intent…is to make the subject very disturbed, but with the presumption that he will recover." "The plan is to rapidly overwhelm the subject, while still allowing him the option to choose to cooperate at any stage as the pressure is being ratcheted up. The plan hinges on the use of an absolutely convincing technique. The water board meets this need. Without the water board, the remaining pressures would constitute a 50 percent solution and their effectiveness would dissipate progressively over time, as the subject figures out that he will not be physically beaten and as he adapts to cramped confinement."[29]

DoJ's Office of Legal Counsel (OLC) prepared three memoranda in response to the Agency request, all dated 1 August 2002. An unclassified "Legal Memorandum, Re: Standards of Conduct for Interrogation…" spelled out in broad detail what would and would not fall within the provisions of the Torture Convention, as implemented within the United States. A second unclassified memo concluded that under international law, interrogations not barred within the U.S. would not be within the jurisdiction of the International Criminal Court. The third, classified memorandum, applied the judgments of the first two to the interrogation of Abu Zubaydah. This explicit memo, entitled "Interrogation of al Qaeda operative," summarized the proposed techniques, their record in the SERE program, and the proposed medical safeguards, then advised—per the Legal Memorandum—that torture, as legally defined, was "the infliction of severe physical or mental pain or suffering;" that severe *physical* pain "is pain that is difficult for the individual to endure and is of an intensity akin to the pain accompanying serious physical injury." Their conclusion was that "[n]one of the proposed techniques inflicts such pain." These explicitly included slaps, walling, stress positions, confinement boxes, sleep deprivation, and the waterboard. Nor did the waterboard legally "inflict severe [physical] suffering," because it was "simply a controlled acute episode, lacking the connotation of a protracted period of time generally given to suffering."[30]

With regard to whether the techniques inflicted severe *mental* pain, DoJ wrote that to be prohibited by statute they would have to cause "prolonged mental harm," "disrupt profoundly the senses or the personality" (i.e., through the administration of a "mind-altering substance or procedure") or threaten imminent death. With the exception of the waterboard (and mock burial, which had been dropped from consideration), none of the techniques therefore was prohibited. "Although the waterboard constitutes a threat of imminent death," the SERE record indicated that it did not cause the requisite

[29] OMS was not part of the preparation of these papers and first saw them the following spring, 2003. The DoJ August 1, 2002 memorandum on "Interrogation of al Qaeda Operative," which was provided to OMS in summer 2002, did quote or summarize some portions of the OTS-prepared material.

[30] Memorandum for John Rizzo, Acting General Counsel of the Central Intelligence Agency, "Interrogation of al Qaeda Operative," 1 August 2002. A separate, unclassified memo that date, stated, "Physical pain amounting to torture must be equivalent in intensity to the pain accompanying serious physical injury, such as organ failure, impairment of bodily function, or even death." Legal Memorandum, Re: Standards of Conduct for Interrogation under 18 U.S.C. 2340-2340A (1 August 2002), in Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 19.

"prolonged mental harm,…e.g., mental harm lasting months or years." Thus the use of this procedure "would not constitute torture within the meaning of the statute."[31]

(b)(1)
(b)(3) NatSecAct

With both definitive DoJ legal guidance and White House concurrence in hand, on August 3rd the field was cabled approval to proceed. Notwithstanding the reported safety of the SERE measures, OMS believed the presence of both a physician and the PA was warranted, at least during waterboard applications. In anticipation of DoJ approval, two RMOs had been asked if they were willing to participate, and both agreed. In early July [redacted] RMO, en route to a temporary assignment [redacted][2] was met and briefed at Dulles Airport. At the end of July, upon oral approval from DoJ (and the White House), he was dispatched [redacted] to await the written approval. At [redacted] RMO reconfirmed AZ's basic good health, and reported to OMS a local belief that the enhanced measures would succeed within 72-96 hours, i.e., within the length of a typical SERE program. After a week the [redacted] RMO, who had accompanied the initial AZ rendition, was to relieve this RMO; he, too, was brought to Washington for a briefing.

During the upcoming period of intense interrogation, AZ was to be given the impression that he could not escape into an alleged need for medical care. Medical attendants would no longer dress his wound; rather, a guard occasionally left dressings and antiseptics with which he was to take care of himself. In actual fact, this "guard" was a PA or physician (with face covered, as were all the guards), who carefully monitored the wound, and made any necessary cuts of the tape as AZ took care of the dressing.

[31] Memorandum for John Rizzo, Acting General Counsel of the Central Intelligence Agency, "Interrogation of al Qaeda Operative," 1 August 2002. In the separate unclassified memo of that date, DoJ also wrote, "For purely mental pain or suffering to amount to torture under Section 2340, it must result in significant psychological harm of significant duration, e.g., lasting for months or even years." Legal Memorandum, Re: Standards of Conduct for Interrogation under 18 U.S.C. 2340-2340A (1 August 2002), in Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 19.

(b)(1)
(b)(3) NatSecAct

Initiation of "Enhanced Interrogation Techniques" (EIT's)

On August 4th, "enhanced interrogation techniques" were begun. Within six hours these progressed from attention slaps and walling to confinement in both the large (about 5 hours) and small (about 1 hour) boxes, and finally to the water board. The initial waterboard sessions lasted about two hours, although with significant breaks and with no single application exceeding 17 seconds; and none exceeding 30 seconds in a later second session.[33] After a final half-hour in the small box, AZ was left overnight in the large box. Medical—which remained continuously on-site throughout the intense phase of interrogation—monitored AZ's condition throughout the night via a grainy video feed from inside the box. The next day, 5 August, AZ was subjected to a similar course. Neither day produced notable intelligence. Despite willingness to give other kinds of information, AZ was sticking to his previous statement that he had disclosed what little he knew on imminent threats. Informally the RMO wrote that AZ "seems amazingly resistant to the waterboard" and was "becoming habituated to the boxes." Contrary to expectations, the process was going to take "a long time." The whole experience, the RMO added, was "visually and psychologically very uncomfortable" for all those witnessing it.[34]

EITs continued to be applied with varying degrees of intensity until the morning of 8 August, when a particularly aggressive session left AZ highly distraught, and some of the on-site staff profoundly affected. In the wake, the on-site personnel concluded the intense phase should not be continued much further, and that senior CTC personnel needed to see the process first hand. The same protocols nonetheless were continued for the next few days, as plans were made for a video-teleconference (VTC) with headquarters. The on-site medical role began to include staff counseling.[35]

(b)(3) CIAAct
(b)(6)

On August 13th, the VTC was held, including video clips from the full range of interrogation efforts. [redacted] OMS was one of those in attendance. Despite a grainy appearance, the intensity of the ongoing interaction was graphically evident. CTC analysts, however, remained convinced that AZ had detailed time-perishable information,

---

(b)(1)
(b)(3) NatSecAct

[33] The waterboard was positioned slightly head down—as was done in SERE—and included a capability to quickly pivot to a vertical position to facilitate clearing the air passages.[33] The medical team had limited AZ to liquids for several hours preceding this exposure, but when his anticipated vomiting included solids from early that morning, he was restricted to liquids only for the duration of the intense phase.

(b)(3) CIAAct
(b)(6)

[34] Lotus Note, [redacted] Medic to [redacted] MS, 5 August 2002, SECRET

[35] Thought was given locally to bringing in a staff psychologist or psychiatrist to work with the staff. The on-site OTS personnel objected to this, a reflection of long-standing antipathy between OMS and OTS on the psychology side, and an OTS belief that they should control all "operational psychology." As these were potentially staff consultations, this argument wasn't accepted. However, it was decide that a more practical approach was to have OMS staff evaluate/counsel all staff personnel on their return from [redacted] (and psychologically prescreen anyone being sent out to [redacted] or other future detention sites).

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

which warranted a continuation of the process.[36] Given the on-site OTS psychologist assessment that AZ's psychological status was fundamentally sound, and the RMO's[37] judgment that the wound still looked acceptable (albeit at some risk if the process continued another two weeks), C/CTC directed the enhanced interrogations to continue. However, to allow AZ more opportunity to cooperate, the breadth of questioning was to be broadened considerably; and all decisions on technique left to those at site.

Enhanced measures continued for the next ten days, albeit at a much lower intensity. The waterboard was applied on only two of those days (August 15 and 19), and for the final three days the small confinement box was not used. Even this limited waterboard use was meant only as a brief reminder when AZ appeared to be backsliding.

Between these final two waterboard sessions, a question was raised by the field about the possible use of a medical "disinhibitor," such as sodium amytal, which prompted another OMS review of "truth serums." Such drugs, although widely regarded as unreliable sources of "truth," were believed potentially useful as an "excuse" that would allow the subject to be more forthcoming while still saving face. While undertaking the review, OMS informally agreed to consider supporting this alternative approach, providing that the actual administration was handled by a qualified physician, e.g., an OMS psychiatrist. In practice, AZ's continued cooperation with the new line of question made new measures unnecessary.[38]

Medically, AZ showed remarkable resilience throughout the process, in part due to a manifest concern for his own physical well-being. The early worry that he would attempt to aggravate his wound, especially while in the confinement boxes, proved entirely unfounded. He always was very attentive to his dressings. The boxes themselves eventually seemed to serve as an escape from more severe measures. During the most physical phase of the interrogation, wound healing did slow, and eventually there was minimal deterioration of some margins. No signs of infection presented, however, and the intense phase of the interrogation ended before further deterioration would have forced medical intervention.

During the final, transition phase of enhanced interrogation (which began on August 19th and ended the 23rd), AZ was in an increasingly benign environment. This allowed solid food, greatly improved hygiene, and the resumption of more active medical care. The edges of his wound quickly recovered, and the healing in of the basic defect resumed. When AZ entered the "debriefing" mode, both the RMO and the PA were able to depart, replaced—as previously—by headquarters-based nurses, who attended to the healing leg wound.

(b)(1)
(b)(3) NatSecAct

[36] On-site personnel came to believe that Headquarters thought the field had lost its objectivity.
[37] By this time [redacted] RMO had replaced [redacted] RMO.

(b)(1)
(b)(3) NatSecAct

[38] Another question raised was whether a small amount of shrapnel, still imbedded in his parietal lobe after a war injury some years earlier, could explain his failure to recall certain details. Our consultants judged not.

(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

Within two weeks questions about AZ's candor again were raised and RMO was sent for against the possible resumption of more intense methods. Enhanced methods proved unnecessary, but during the RMO's weeklong stay at the RMO flew down to be briefed into the program. To further build the support cadre, th(b)(1) RMO was recalled to headquarters for the same briefing. (b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

On , as RMO returned the U.S. raised its terror alert level to "orange" [high], and precipitously closed thirteen embassies and consulates. (b)(1)

(b)(1)
(b)(3) NatSecAct

(b)(3) NatSecAct

No attacks materialized, but the anxiety level remained high. In the Washington, D. C. area, five separate "sniper" attacks the first week in October, left five random Washington area residents dead—all killed as they went about routine daily activities. For three difficult weeks, until the killers were captured, the sniper attacks were believed by some to be another terrorist assault. Amidst this local angst, on October 12th, the al-Qa'ida-affiliated JI bombed a nightclub in Bali, killing 202 people.

(b)(1)
(b)(3) NatSecAct

Amidst these ongoing developments, two other "high value targets" (HVTs) were captured who eventually would be handed over to CTC. One was Ramzi Binalshib, a former member of the Hamburg 9/11 cell arrested in Karachi on September 11th.

(b)(1)
(b)(3) NatSecAct

In mid-October, about the time of the Bali bombing, Abdul Rahim al-Nashiri was arrested Nashiri was al-Qa'ida's senior representative in the Persian Gulf, and believed directly linked to both the East African embassy bombings and the bombing of the *USS Cole*.

(b)(1)
(b)(3) NatSecAct

Anticipating the transfer of at least one of these HVT's, RG hurried to complete a second facility,

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1) (b)(3) NatSecAct On November, Nashiri was transferred to Agency custody, and flown on an Agency rendition flight to an Agency facility Both an OMS PA and contract psychologist-interrogator Mitchell accompanied this rendition. At Mitchell and Jessen (who had been there assisting with interrogations for the preceding two weeks) prepared a mental status evaluation, an assessment of Nashiri's "resistance posture," and proposed an "interrogation plan." Nashiri, then age 37, had seemed arrogant and immature, transparently feigning distress, and provocatively disrupting his interviews and questioning, but was without apparent mental disorders. The plan was to move him to where, if he remained uncooperative, he would be subjected to increasingly intense enhanced interrogation measures. At headquarters, an OTS psychologist reviewed the assessment and plan, and agreed that there was no evidence Nashiri would be unable to endure enhanced measures or that they would cause him "severe, profound, or permanent harm." A physician thus was needed to monitor his planned interrogation.

(b)(1) (b)(3) NatSecAct Nashiri was moved to The RMO, summoned to rejoin the on-site PA, arrived on At Nashiri immediately was subjected to slaps, walling, and the confinement boxes (which, because of his small stature, proved a relatively benign sanctuary). A week later, after some perceived success, these intense measures were suspended, and the RMO departed. Unexpectedly a combination of urgent concerns led to another day of aggressive interrogation, on November before the RMO could arrive. These measures, which included all the previously applied measures plus 1-3 brief applications of the waterboard, were monitored by the PA and accomplished without complication.[41]

(b)(1) (b)(3) NatSecAct (b)(1) (b)(3) NatSecAct now was available, so interrogations were suspended and plans laid for a quick departure The arrival of the RMO allowed the on-site PA—who was to accompany the transfer—to visit and buy cold-weather clothes. On December the transfer was effected. Medically, both detainees were in good shape. AZ's leg wound now measured only a 1x2 cm, and was easily covered by a small bandage. Both detainees were shackled and hooded for the trip, and transported lying on their sides.[42] Initially the rendition crew proposed a gag and duct tape to prevent communication, but this was overruled by the PA. Airsickness could lead to vomiting and, with mouths blocked, to aspiration.

[41] The PA wrote of only one session, a later IG review said two, and a later CTC summary said three; all agreed that these were of very short duration.

[42] Hooding during transfer was primarily for security reasons, to prevent detainees from identifying their locations. Eventually medical personnel became concerned that in some cases hood might unacceptably restrict air flow, so during flights detainees were monitored with pulse oximeters. If oxygen saturation began to drop, the hood was pulled above the nose. This problem eventually was remedied by replacing hoods with eye patches and opaque goggles.

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct

The late December *Washington Post* article was among the first to claim knowledge of the Agency's interrogation techniques. "Sources" did correctly report (or guess) that these techniques included sleep deprivation ("a practice with ambiguous status in international law"), and stress positions. They erred in alleging manipulation of Zubaydah's medical care: "National security officials suggested that Zubaida's painkillers were used selectively in the beginning of his captivity...." [45] This speculation, echoed in a *Post* editorial, was repeated more emphatically just a few months later by both the *Los Angeles Times* and *New York Times* ("U.S. officials admitted withholding painkillers;" "painkillers were withheld from Mr. Zubaydah"). And from there, it immediately went to the editorial pages of the *British Medical Journal*, which asked if "the doctors assigned to US interrogation centres protested...at the denial of painkillers to Abu Zubaydah." [46] In late 2005, "an authoritative U.S. official" finally was quoted as saying that the pain medication story "never happened." But by then it had become an accepted "fact," a fact soon to be more permanently enshrined in books. [47]

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct

[45] "U.S. Decries Abuse but Defends Interrogations," *Washington Post*, 26 December 2002.
[46] "Fighting 'terrorism' with torture," BMJ 326:773-774 (12 April 2003).
[47] "Torture is Not an Option," *Washington Post*, 27 December 2002; "Rights on the Rack," Los Angeles Times, 6 March 2003; "Questioning Terror Suspects in a Dark and Surreal World," *New York Times*, 9 March 2003. Some later repetitions: "U.S. Pledges to Avoid Torture," Washington Post, 27 June 2003 ("Officials said painkillers were used selectively to win cooperation of Abu Zubaida"); "Hussein Disoriented, Defiant, Sources Say," *Washington Post*, 15 December 2003; "The Policy of Abuse," *Washington Post*, 16 May 2004; "CIA Puts Harsh Tactics On Hold," *Washington Post*, 27 June 2004; "Disclosure of Authorized Interrogation Tactics Urged," *Washington Post*, 3 July 2004; "The CIA's Prisoners," *Washington Post*, 15 July 2004; "C.I.A. Expands Its Inquiry Into Interrogation Tactics," *New York Times*, 29 August 2004; "Vice President for Torture," *Washington Post*, 26 October 2005 The lone contradictory voice is found in "Italy presses U.S. on torture claim," *Chicago Tribune*, 28 December 2005. Among the books repeating this claim: Gerald Posner, *Why America Slept: The Failure to Prevent 9/11* (New York: Random House, 2003, pp. 184-186; Sanford Levinson, ed., *Torture: A Collection* (Oxford:

(b)(3) NatSecAct

(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

The question of drug-assisted interrogation

The intensity and duration of AZ's interrogation came as a surprise to OMS and prompted further study of the seemingly more benign alternative of drug-based interviews.[48] The only readily accessible summary of the Agency's extensive early experience was a spring 1961 *Studies in Intelligence* article, "'Truth' Drugs in Interrogation," which had concluded,

> No such magic brew as the popular notion of truth serum exists. The barbiturates, by disrupting defensive patterns, may sometimes be helpful in interrogation, but even under the best conditions they will elicit an output contaminated by deception, fantasy, garbled speech, etc. A major vulnerability they produce in the subject is a tendency to believe he has revealed more than he has. It is possible, however, for both normal individuals and psychopaths to resist drug interrogation; it seems likely that any individual who can withstand ordinary intensive interrogation can hold out in narcosis.[49]

This wasn't necessarily the final word, however, even in 1961; Technical Services Division (TSD, predecessor to OTS) was in fact using drugs in interrogation about that time (notably LSD), and MKULTRA drug research continued at least two more years. Additionally, the 1963 *KUBARK [CIA] Counterintelligence Interrogation* manual, still included drugs among the potentially useful interrogation tools, if only for a placebo effect, or to allow the subject to rationalize giving up information.[50]

An OMS staff psychiatrist obtained from the DO's Central Eurasian Division a compilation of reporting on the Soviet drug program. OMS was aware that studies of communist "brain washing" techniques in the 1950s and 1960s had concluded that Soviet, Satellite, and Chinese successes at "mind control" were achieved without the use

[48] Similar thinking was partially responsible for interest in the use of "truth serums" in the 1930s; they avoided the more physical measures then in use by some police departments.

[49] George Birmmerle, "'Truth' Drugs in Interrogation," *Studies in Intelligence* 5(2):A1-A19 (Spring 1961). Geroge Bimmerle was a pseudonym for a TSD/Behavioral Activities Branch (BAB) non-scientist working principally as a researcher and writer, but once involved in surreptitious LSD administration. This article apparently was prepared with help from Dr. Edward Pelikan, a consultant pharmacologist formerly on the Technical Services Staff (TSS, predecessor to TSD). In 1977 the Agency introduced the text of this article, without title, author, date or sourcing into Congressional Hearings on MKULTRA, as a statement of then current thinking on drugs in interrogation. LSD received only the passing comment that "information obtained from a person in a psychotic drug state would be unrealistic, bizarre, and extremely difficult to assess... Conceivably, on the other hand, an adversary service could use such drugs to produce anxiety or terror in medically unsophisticated subjects unable to distinguish drug-induced psychosis from actual insanity."

[50] *KUBARK Counterintelligence Interrogation* (1963), 99. 131 (SECRET). While no author is listed, the manual was prepared by or jointly with the TSD/BAB psychology staff. A redacted version of this manual was released to the public in 1997.

of drugs. The 2002 CE data was consistent with this, in suggesting that the most intense period of Soviet drug study had not come until the 1980s, in the wake of intense 1970's publicity surrounding the Agency's drug programs. It appeared that the Soviets had looked into drugs similar to those once investigated by the C.I.A. and U.S. military (e.g., psychotomimetics, barbiturates), and—as in the U.S.—had failed to find any particularly useful drug.[51]

The issue of drug-based interrogation vs. SERE techniques was discussed with three OMS field-based psychiatrists at a Mental Health Division (MHD) field conference the first of October. All had been exposed to amytal interviews during their residency training or later, typically treating hysterical paralysis. The goal of the interviews had not been to establish actual facts, but rather to seek the "psychological truth" behind the condition. The psychiatrists, while not optimistic, thought that given the alternatives the subject was worth more study. A long distance dialogue continued for the next 2-3 months, while each did his literature review, and submitted thoughts.

Eventually it was decided that the most promising approach would be along the lines of traditional "narco-analysis." Unquestionably some false information would result, as was the case with more physical methods, but this wasn't necessarily a showstopper. Even the unreliable barbiturate interviews of the 1950s, in the hands of sophisticated analysts, sometimes provided useful leads.

The preferred drug appeared to be midazalam (Versed), a comparatively new benzodiazepine. Versed was one of the safest and most easily reversed benzodiazepines, and clearly much preferable to the older barbiturates. It also afforded some amnesia, a sometimes desirable secondary effect. A downside was a requirement for (presumably) physician-assisted intravenous administration, which decades before had been an argument against barbiturate interrogations—vice LSD which could be administered "silently."

Ambivalently, Versed was considered possibly worth a trial if unequivocal legal sanction first were obtained. There were at least two legal obstacles: a prohibition against medical experimentation on prisoners, and a ban on interrogational use of "mind-altering drugs" or those which "profoundly altered the senses." The latter seemed clearly aimed at hallucinogens like LSD (a legacy of MKULTRA), but the legal status of more traditional "truth serums" was not clear beyond the inadmissibility in court of information obtained under their influence. The question became moot, since CTC/LGL did not want to raise another issued with the Department of Justice.

---

[51] "Drug Assisted Interviews," 10 September 2002, (SECRET) Several years later, a laborious review of Agency archival materials made possible the reconstruction of much of the early record on drug-assisted interrogation. This clarified the actual practice and conclusions at the time, but did not identify any particularly useful technique.

At the beginning of 2003 the OMS review (informally termed "Project Medication") was shelved, never to be reactivated. In retrospect, even had there been legal sanction, an opportunity to try drug-assisted interrogation may never have presented. An interrogation of the intensity of the AZ case was repeated only once thereafter, in a particularly high profile case; in all other cases, less robust methods seemed adequate. As OMS gained more familiarity with successful interrogation, another drawback to the use of a drug like Versed became evident. As a measure of accountability, coercive measures were increased when detainees intentionally provided provably false information. A detainee speaking under the influence of drugs, however, could credibly claim ignorance of anything he had said.

Failure to pursue the option of drug-assisted interrogation also spared OMS physicians some significant ethical concerns. Throughout its support of the RDG program, OMS scrupulously avoided involuntarily medicating detainees. With rare exception, detainee treatment was given only after first obtaining consent; if refused, the treatment was not given.[52] Though perhaps unlikely, it was possible that some detainees would consent to a drug-assisted interview—to "prove" that they were not withholding information. (This sometimes had been the case in both police and early Agency use of the historic truth drugs.) Whether or not consent was obtained, drug administration—presumably by a physician—clearly would have been an invasive procedure for non-therapeutic reasons.[53]

Notwithstanding the actual record, in 2003 a detailed but imaginary account was published of Agency medical personnel using Sodium Pentothal on Abu Zubaydah, who "evidently [was] the first to be given thiopental sodium."[54] Remarkably, this claim was rarely if ever repeated. When the opportunity later presented to discuss interrogation techniques with a Congressional Committee, the Agency was asked why it had *not* used drugs. The answer was that drugs don't work—which is true, probably.[55]

---

[52] Only twice had violently disruptive individuals been sedated—once during a rendition, and once in detention—to avoid self-harm or endangerment to others. A few detainees on hunger strikes were involuntarily fed through a NG tube, but always with their assistance.

[53] When first discussed, the personal ethics of some of the physician staff probably would have allowed participation in legally sanctioned drug-assisted interrogations, as a more benign alternative to the very aggressive approach being employed. When waterboard use effectively ended after March 2003, the ethical equation may well have changed.

[54] Gerald Posner, *Why America Slept: The Failure to Prevent 9/11* (New York: Random House, 2003, pp. 187-188. Posner also claimed, incorrectly, that Zubaydah was hooked to a polygraph during this time.

[55] Several years later, a laborious review of Agency archival materials allowed a reconstruction of much of the early record on drug-assisted interrogation, which clarified the actual practice but did not identify any particularly useful techniques. Both barbiturates and hallucinogens seemingly had produced compliance or useful reporting in some cases, but this was against a backdrop of confabulations or deliberate misreports. For bureaucratic reasons as much as anything, LSD eventually displaced the conventional medical use of barbiturates in interrogation. Given LSD's associated medical risks and emerging societal strictures, its use later was abandoned. Objectively, aside from ease of administration it offered no more than the barbiturates beyond scaring some into cooperation.

The Role of Psychologists and Psychiatrists

The AZ interrogations highlighted just how challenging the emotional context would be, both for detainee and those present. As a result, in mid-August 2002 MHD began a debriefing assessment of all employees returning from detention sites, and by month's end was screening all those being assigned to these sites. When an interrogator training program was begun in November, candidates first had to be evaluated by MHD.

(b)(1)
(b)(3) NatSecAct

MHD (and the OMS front office) also began quiet inquiries into the philosophy and operation of existing SERE programs. In early November 2002 a SERE psychologist assigned to the Army's Fort Bragg program spoke to an OMS/MHD [redacted] detailing the specifics of their training. The Bragg program made aggressive use of the same techniques used against AZ (other than the waterboard) and also forced trainees into a cold outdoor pool (even in winter). The role of the psychologist and a physician in the SERE program was to prescreen the students for any disqualifying physical or psychological problems, and to intervene if a student seemed at risk or an instructor became too aggressive. Their judgment on these questions was final.

At this offsite there was a lengthy discussion of the ethics of psychologist involvement in interrogation programs, particularly one modeled after SERE. The general consensus was that, given the legal rulings in hand, no ethical bar existed to *non-mandatory* participation. The appropriate psychologist role was to assess and monitor detainees and staff—as in the SERE program—but with no involvement in the actual interrogations (unless the psychologist role had been relinquished).

This psychologist role soon became a point of tension between OMS and CTC, prompted by OTS advertising for senior "psychologist/ interrogators" during the summer and fall of 2002. Psychologist/interrogators were to be "operationally oriented psychologists who are willing to support the interrogations of high value targets," "provide psychological guidance to the interrogation team chief," and "directly participate in the interrogations." Consistent with this, the on-site contract psychologist interrogators sometimes had assumed dual roles of interrogating and assessing the psychological stability of the same detainee. Similarly, the on-site OTS staff psychologist also served a hybrid function—performing detainee mental status assessments while actively contributing to the interrogation plan. OMS believed this combination of responsibilities to be inappropriate.

(b)(1)
(b)(3) NatSecAct

The issue was partially resolved in December 2002, when RDG assumed responsibility for the management [redacted] OTS did not have the manpower to provide regular coverage, so OMS took this over. At the time and for the next three months, no active interrogations were undertaken, so the role of the psychologist was limited to the initial assessment of new arrivals and mental health monitoring of those in detention. On one occasion, the OMS psychologist did bar the aggressive interrogation of a new arrival, who he found to be too psychologically vulnerable.

(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

OTS still wanted to cover the highest profile cases, so when an HVD (Asadullah) arrived [redacted] 2003, their psychologist (previously on-site with AZ) arrived to provide support. When two even more important HVDs were captured and rendered [redacted] a coverage problem developed. One of these was al-Qa'ida operations chief Khalid Shaykh Muhammed (KSM) who was to be sent on to [redacted] The other was key al-Qa'ida financial facilitator Mustafa Ahmad al-Hasawi [redacted] who was to stay [redacted] The OTS psychologists (and an RMO) went with KSM [redacted] and an OMS psychologist took over responsibility for monitoring the Hasawi interrogation. With rare exception OMS handled cases thereafter.

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

OTS (and the contract psychologist/interrogators) provided the psychological services to [redacted] from the time it opened in December 2002. That month, coincidentally, saw publication of the American Psychological Association's newly revised "Ethical Principles of Psychologists and Code of Conduct."[56] The APA advised that psychologists should "refrain" from entering a "multiple relationship [with a person] if [this] could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness,....or otherwise risks exploitation or harm."[57] In partial response to OMS bringing this to the attention of CTC, [redacted] Special Missions Division (SMD)—under which RDG was located—advised [redacted] in late January:

(b)(3) CIAAct
(b)(6)

> It has been and continues to be [Agency] practice that the individual at the interrogation site who administers the techniques is not the same person who issues the psychological assessment of record.... In this respect, it should be noted that staff and IC psychologists who are approved interrogators may continue to serve as interrogators and physically participate in the administration of enhanced techniques, so long as at least one other psychologist is present who is not also serving as an interrogator, and the appropriate psychological interrogation assessment of record has been completed.[58]

This guidance required that the psychologist who did the initial assessment not also administer EITs, but did not preclude a psychologist from alternating between an interrogator/interrogation consultant role and a psychological assessment role once the initial pre-interrogation assessment was complete. This, OMS believed, was a major concern.

(b)(3) CIAAct
(b)(6)

In defending the extant practice, [redacted] SMD solicited further input from both the psychologist/interrogators and a distinguished senior contract psychologist (already

[56] These were adopted in August 2002, and became effective 1 June 2003.
[57] Ethical Standard 3:05 Multiple Relationships.
[58] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 40.

working for both OMS and OTS). They jointly argued that, contrary to OMS, the Code of Ethics provided a relevant exemption from the warning against dual roles, "[w]hen psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings."[59] This exemption, for example, allowed a prison psychologist who unexpectedly uncovered evidence of a serious crime while treating a prisoner to testify against the prisoner. OMS believed this might well cover a dual role in which a psychologist did mental health monitoring of an interrogation, and provided other clinical support to the same individual, but rejected the notion that it possibly could extend to working both as a psychologist and an interrogator on the same person.

(b)(1)
(b)(3) NatSecAct

In early March, the [redacted] OMS Regional Psychiatrist visited [redacted] and reported, "It's clear that OTS has no real interest in acting as the mental health component of the interrogation team—except as it directly applies to interrogation. They are not supporting the team as an impartial exogenous superego that provides unbiased clinical assessments and addresses individual and team issues with regard to the psychological process being applied to the detainee. That would require a clear delineation of roles....their conflict of interest is resolved by focusing their energies on the interrogation and not on team and individual dynamics."

(b)(1)
(b)(3) NatSecAct

Manpower limitations finally resolved the issue at [redacted] as they had at [redacted] OTS still did not have the staff to cover the expanding program, so in April 2003 OMS took over psychological coverage [redacted] Thereafter OMS provided almost all the psychological services to future detention sites, supplemented periodically by the OTS psychologist who had been active in the program from the beginning. As OMS assumed more responsibility, OMS psychologists and psychiatrists began to attend (as observers) a new Agency High Value Target Interrogation training class.[60] Some visited SERE programs and consulted with SERE psychologists. Finally, in summer 2003, the MHD psychologist who handled the Hasawi case was transferred full-time to the RDG staff, to provide primary coverage and coordinate the support of other OMS psychologists and psychiatrists. By 2007 [redacted] OMS psychologists and [redacted] (b)(3) CIAAct psychiatrists had provided some support to the program.

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(3) CIAAct

(b)(3) CIAAct
(b)(6)

[redacted] SMD's support for the contract psychologist/interrogators was attributable to their being viewed as the Agency's most skilled and successful interrogators and indispensable to what was emerging as the Agency's most productive counter-terrorist program—alone accounting for over half of all al-Qa'ida-related intelligence. So highly regarded were these contractors that they commanded ready entrée to the Agency's most

[59] Ethical Standard 3:05 Multiple Relationships.

[60] Beyond its intrinsic value, this participation addressed a lingering question about OMS involvement in the interrogation program. Amidst the January 2003 OMS-OTS tensions surrounding ethics and coverage, OTS had announced a "requirement" that formal SERE training would be prerequisite to serving as a "Special Mission" psychologists. While not enforced by CTC, the lack of OMS SERE experience was a recurring OTS theme until summer 2003.

senior management and four times the compensation of other interrogators. Given this, (b)(3) CIAAct SMD still sought opportunities to further utilize their services as psychologists. Over (b)(6) the next year, this infrequently generated tasking to psychologically evaluate those they once had interrogated. Each time OMS objected, reluctantly agreeing that the contract psychologist/interrogators could possibly perform assessments without conflicting interests on those with whom they had had no dealings as interrogators. The OMS preferred solution was that these contractors choose one role or the other, not both. In May 2004 the first Inspector General report on the interrogation and detention program reviewed this history, noted the continuing OMS concerns and formally recommended a policy that "individuals assessing the medical/psychological effects of EITs may not also be involved in the application of those techniques."[61] The notion of "psychologist/interrogators" then disappeared, and the SERE contractors worked solely on the interrogation side.[62] That summer the Department of Justice, after reviewing the IG report, asked OMS if the problem had been resolved, and OMS finally could agree that it had.

An early task of the OMS psychologist detailed to RDG was the creation of relevant standard operating procedures (SOPs). By December 2003, and with the input of other OMS psychologists, this had grown into extensive guidance for psychologists participating in the RDG program. Specifically addressed were Qualifications and Training; Psychological Support to Interrogations/ Debriefings; Standards of Care; Guidance and Definitions For Mental Health Assessment of CIA Detainees (including a requirement for daily assessment during enhanced measures); Psychological Disturbance; Assessment of Long-term Functioning and Mental Status; Standard Operating Procedures for Mental Health Emergencies; PIA Interview (a pre-interrogation face-to-face interview assessing psychological stability, mental status, resistance posture, and suitability for enhanced measures); and even Cable Format. An appendix addressed "Ethical Standards for Psychologists Providing Support to CTC/RDG Operations," which was adapted from APA's 2002 "Ethical Principles of Psychologists and Code of Conduct."[63]

OMS psychologists nonetheless sometimes found themselves operating in a gray zone, as they alternated between operational and clinical roles in supporting the program. They assessed mental status and monitored psychological well-being, but also looked for any apparent factors which would preclude the use of enhanced interrogation techniques (e.g., a history of abuse or some significant psychological problem). If enhanced measures were employed, the psychologist reassessed the detainee's psychological state

[61] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 35, 106.
[62] Eventually allowing their psychology licenses to lapse, Jessen and Mitchell launched a very successful business—Mitchell, Jessen and Associates--which provided guards, interrogators, and debriefers to the CTC program.
[63] "Psychological and Psychiatric Support to Detainee Interrogations," in draft, 10 December 2003. [14 pp + 9 pp appendix

on a daily basis. While never recommending specific coercive measures (e.g., on the basis of perceived vulnerabilities), they did make recommendations on positive incentives for cooperation (e.g., playing to a narcissistic ego, or providing extra social contact in those for whom socialization seemed exceptionally important).

(b)(1)
(b)(3) NatSecAct

This nonetheless was an uncomfortable, somewhat dual role. Thought was given to establishing separate operational and clinical teams to handle these two dimensions, but there never were enough resources, and with the passage of time the issue was resolved by the disappearance of subjects for aggressive interrogation. In 2005, the APA first addressed the national security context, but by then the issue was largely moot. (See the discussion under *Exposés and Ethics*.) Initial psychological assessments of potential candidates (most never subjected to EITs) had fallen from perhaps [redacted] in 2003, to [redacted] number in 2004, to about [redacted] in 2005, and [redacted] in 2006. Detainees subjected to enhanced measures declined from [redacted] in 2003, to [redacted] in 2004, and [redacted] in 2005. After 2004, at least 97-98% of the work was purely clinical, in the form of quarterly mental health clinical visits—by either a psychologists or a psychiatrist—[redacted] detainees in as many [redacted] locations. As a practical matter, the dual operational-clinical role had all but disappeared.

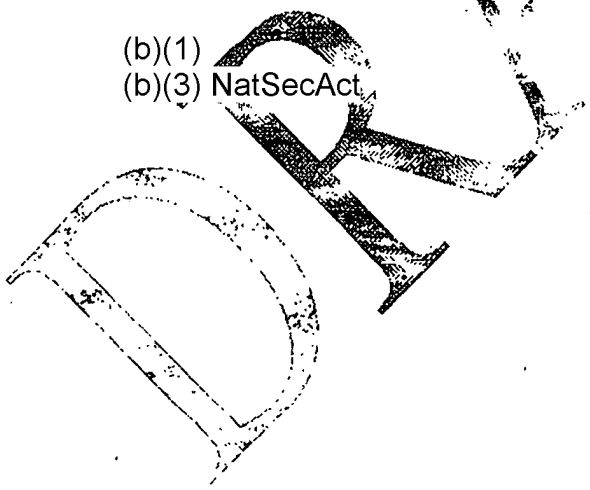
(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct



Early Mistakes

From the very outset, the detention and interrogation of High Value Targets received extraordinary guidance and oversight, in part because of AZ's physical condition, in part because of the legal issues surrounding aggressive interrogation, and in part because of felt urgency in gaining the cooperation of detainees. This attention was focused almost exclusively on the HVT facilities, initially [redacted] and then [redacted] and its successors. It was attentively managed by the Rendition Group, overseen by CTC/Legal, and had an on-site staff which variously included physicians, psychologists, PA's, nurses, and Agency security officers, in addition to the CTC interrogators and debriefers.

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

Even so, this was a work in progress, and occasionally an unthinking or unauthorized improvisation crossed the bounds of acceptability. When identified, these were immediately corrected and, if appropriate, the perpetrators disciplined. Given the degree of oversight, this was an early and uncommon occurrence at HVT facilities; and typically occurred in the absence of the interrogation staff. The target of several of these excesses was Nashiri, whose immaturity regularly provoked the staff. He again was subjected, with RG approval, to stress positions and sleep deprivation on arrival at [redacted] At one point, however, an interrogator inappropriately lifted Nashiri by his arms belted behind his back, which was both painful and medically risky. The onsite PA intervened, and the maneuver was not repeated. A few weeks later a debriefer, absent the interrogation team and PA, reinstated sleep deprivation, then tried to intimidate Nashiri by hooding him, spinning the magazine of a revolver, and starting up a power drill (albeit not actually touching the detainee). These actions led to disciplinary measures.[64]

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

Not all early Agency detainees were held in these carefully overseen RG HVT facilities. Many suspected terrorists were rounded up during military action in [redacted] some of potential intelligence value. [redacted]

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

[redacted] also had no written interrogation guidelines, though early on was granted permission to employ sleep deprivation, solitary confinement, noise, and

[64] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 41-44. Nashiri also had cigar smoke blown in his face, and may have been scrubbed with a wire brush.

(b)(1)
(b)(3) NatSecAct eventually standing sleep deprivation, nakedness and cold showers. As these were not "enhanced" techniques, no medical monitoring function was specified, nor was OMS advised of interrogations. When detainees needed medical care, the PA
(b)(1)
(b)(3) NatSecAct assigned TDY was called. This happened every week or two, largely for entirely routine complaints.[65] Interrogators at left to their own devices, sometimes improvised. These improvisations varied from unauthorized SERE techniques
(b)(1)
(b)(3) NatSecAct such as smoke blown into the face, a stabilizing stick behind the knees of a kneeling detainee, and cold showers, to undisciplined, physically aggressive "hard takedowns" and staged "executions" (though the latter proved too transparent a ruse).

(b)(1)
(b)(3) NatSecAct The only death tied directly to the detainee program took place in this context at It came about as the result of an inexperienced local staff being left without clear guidance, or any monitoring requirement, at a time of dramatic temperature change.

(b)(1)
(b)(3) NatSecAct October 2002, a suspected Afghan extremist named Gul Rahman was captured in Pakistan, and on November rendered to His principle
(b)(1)
(b)(3) NatSecAct interrogator was psychologist/interrogator Bruce Jessen, on site to conduct in-depth interrogations of several recently detained al-Qa'ida operatives. For a week, Rahman steadfastly refused to cooperate despite being kept naked and subjected to cold showers and sleep deprivation. Jessen was joined by psychologist/interrogator Mitchell on
(b)(1)
(b)(3) NatSecAct November (At this time the PA visited and found no pressing medical problems,[66] but in view of a recent temperature drop recommended that
(b)(1)
(b)(3) NatSecAct the detainees be provided with warmer clothing (between November and the low had fallen eleven degrees to about 31°F). the psychologist/interrogators performed a final mental status exam on
(b)(1)
(b)(3) NatSecAct Rahman and recommended "continual environmental deprivations." They, (b)(1) PA, then departed the evening of November [67] (b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct Over the next few days, temperatures improved (highs up fifteen degrees lows up nine degrees,) but Rahman's demeanor and level of cooperation did not. When his food was delivered on the he threw it, his water bottle and his defecation bucket at guards, saying he knew their faces and
(b)(1)
(b)(3) NatSecAct would kill them when he was released. On learning this, the Site Manager directed that Rahman, who wore only a sweatshirt, be shackled hands and feet, with the shackles connected by a short chain. As such, he was nearly immobilized sitting on the concrete
(b)(1)
(b)(3) NatSecAct floor of his cell. The temperature had again droppe(b)(1) the preceding evening, and (b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

[67] Many details are in IG Report of Investigation, "Death of a Detainee in " 27 April 2005.

the night Rahman was short-chained reached a low of 31°F. Although Rahman allegedly looked okay to the guards during the night, he was dead the following morning.

(b)(1)
(b)(3) NatSecAct

An autopsy—performed by a (b)(6) pathologist (b)(6) and assisted by the [redacted] PA [redacted] to [redacted]—found no trauma, toxicology, or other pathology to explain the death. On a clinical basis, the
(b)(1)
(b)(3) NatSecAct
pathologist attributed cause of death to hypothermia, consistent with the absence of specific findings. Rahman lost body heat from his bare skin directly to the concrete floor and was too immobilized to generate sufficient muscle activity to keep himself alive.[68]

(b)(1)
(b)(3) NatSecAct

Gul Rahman's death triggered several internal actions, including the generation of formal DCI guidelines on the handling and interrogation of detainees (which basically codified existing RG practice), and the requirement that all those participating in the program document that they had read and understood these requirements.[69] The "Guidelines on Confinement Conditions for CIA Detainees" (28 January 2003) required, among other things: documented periodic medical (and when appropriate, psychological) evaluations; that detainee food and drink, nutrition and sanitary standards not fall below a minimally acceptable level; that clothing and/or the physical environment be sufficient to meet basic health needs; that there be sanitary facilities (which could be a bucket); and that there be time for exercise. The "Guidelines on Interrogations Conducted Pursuant to the Presidential Memorandum of Notification of 17 September 2001" specified that EITs could not be used without prior Headquarters approval, must be preceded by a physical and psychological exam, and must be monitored by medical personnel. Even standard techniques (those deemed not to incorporate significant physical or psychological pressure) required prior approval "whenever feasible." These standard techniques were described as including sleep deprivation (up to 72 hours, reduced to 48 hours in Dec 2003), diapering (generally not to exceed 72 hours), reduced caloric intake (still adequate to maintain general health), isolation, loud music or white noise, and denial of reading material.

(b)(1)
(b)(3) NatSecAct

Renditions and Detainees Group (RDG, the renamed RG) in December was given
(b)(1)
(b)(3) NatSecAct
responsibility for oversight [redacted] Coincident with this, OMS took over psychologist coverage there, which began with the assessment of some [redacted] detainees then on site. The [redacted] PA also began monthly cable summaries of detainee physical health.

(b)(1)
(b)(3) NatSecAct

The deliberate use of temperature extremes as part of the interrogation process eventually became an accepted fact in press coverage of the Agency program. These

[redacted]
(b)(1)
(b)(3) NatSecAct

[69] "Guidelines on Confinement Conditions for CIA Detainees" (28 January 2003)

accounts began in March 2003 with an error-filled, though widely cited *New York Times* piece on interrogation techniques, which included an alleged account of the interrogation at Bagram Air Base of Al-Qa'ida facilitator al-Farouq the previous summer: "[A] western intelligence official described Mr. Faruq's interrogation as 'not quite torture, but about as close as you can get.' The official said that over a three-month period, the suspect was fed very little, while being subjected to sleep and light deprivation, prolonged isolation and room temperatures that varied from 100 degrees to 10 degrees. In the end he began to cooperate."[70] Perhaps because the imagined temperature range was not deemed credible, this claim was not soon repeated.

[redacted]
(b)(1)
(b)(3) NatSecAct

The only time deliberate manipulation of cell temperature was proposed for an RDG detainee came with the capture of Khalid Sheik Mohammed, the most important HVT yet taken. Though not part of DCI guidance, "uncomfortably cool temperatures" were included in the submitted interrogation plan. Reading this, and in view of the recent Gul Rahman experience, OMS sent the attending medical staff some reference material, including WHO-recommended ambient temperature ranges (no lower than 64°), optimal temperatures (78° clothed, 86° unclothed), and the "thermoneutral zone" (68-86°) below which ambient temperature monitoring was necessary.[73] Were a deliberately cool space to be used, the lower limit was 55°, and any confinement between 55-60° limited to 2-3 hours unless the detainee was free to move around or sit on a protective mat. Below an ambient temperature of 64° detainees were to be monitored for hypothermia.

(b)(3) CIAAct
(b)(6)

[redacted] CTC soon specified that detention cells be maintained between 75-78°. Eventually, in June 2004, a DO review of the program noted that "uncomfortably cool temperatures" have "not been used as part of CTC's interrogation program," and

[70] "Questioning Terror Suspects in a Dark and Surreal World," *New York Times*, 9 March 2003. This also was one of the early articles to charge that the Agency withheld painkillers from Zubaydah.

[redacted]
(b)(1)
(b)(3) NatSecAct

recommended that such be deleted from the list of interrogation techniques.[74] OMS personnel confirm that temperature manipulation never became part of the RDG program, and that no RDG detainee was exposed to extreme temperatures. When the 14 remaining HVDs were transferred to Guantánamo in 2006, most reported to the ICRC that initially they were held in cold rooms. Their perception of "cold" was primarily a reflection of personal comfort levels, and not the actual ambient temperature.

[74] Memorandum for Deputy Director of Operations, "Review of CIA Detainee Program in Response to DCI Query," 30 June 2004.

KSM and the Waterboard

The 1 August 2002 DoJ approval letter had characterized the SERE waterboard process, as follows:

> "…once the cloth is saturated and completely covers the mouth and nose, air flow is slightly restricted for 20 to 40 seconds due to the presence of the cloth… [This] produces the perception of 'suffocation and incipient panic,' i.e., the perception of drowning. The individual does not breathe any water into his lungs. During those 20-40 seconds, water is continuously applied from a height of twelve to twenty-four inches. After this period, the cloth is lifted and the individual is allowed to breathe for three or four full breaths…The procedure may then be repeated…."

More broadly DoJ wrote that their general expectation was that "repetition [of any technique, not just the waterboard] will not be substantial because the techniques generally lose their effectiveness after several treatments." On the question of safety, DoJ had written, "You have informed us your on-site psychologists, who have extensive experience with the use of the waterboard in Navy training, have not encountered any significant long-term consequences from its use." Separately, OMS heard from CTC that most SERE programs had dropped the waterboard because it had proven impossible to resist. OTS considered it the most critical element in the program—a point, OMS later learned, explicitly made to DoJ.

Subsequent to the AZ interrogations, OMS learned from medical personnel present at the time that most of his waterboard applications were very brief, though sometimes quickly repeated; the guess was that there had been about 30-40 significant applications. (An IG review of all but one sessions, counting applications as brief as two seconds found a total of 81 exposures, albeit with only three as long as the 20-second SERE minimum.[75]) During these applications a significant amount of water entered AZ's mouth and oropharynx, leading him to swallow as much as he could, and provoking an occasional bout of vomiting. During the second-to-last waterboard session (the twentieth), AZ appeared briefly unresponsive, with his open mouth full of water. The interrogator righted him and applied a xyphoid thrust, with AZ coughing out a copious amount of liquid. This episode, from application to cough, lasted only 8 seconds, and

[75] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 36. On average there were 4 applications per session, with a range of 1-11 and an average application lasting 9 seconds. Twenty-two applications were at least 10 seconds long, but only 3 reached the SERE minimum threshold of 20 seconds. In his 2006 account of this experience to the ICRC AZ stated that when the water was poured he could not breath for "a few minutes" until the bed was rotated into an upright position; and that he had five waterboard sessions of 1-2 applications, and one of 3 applications. He singled out the straps "on my wounds" which attached him to the waterboard as causing severe pain, but in fact the straps were carefully placed to avoid the wounds.

there were no apparent aftereffects. A final session of two brief water applications two days later was accomplished without further problems.

While the experience with AZ supplemented the sparse information available from the DoJ approval letter, it was not apparent to OMS that the AZ applications departed appreciably from the SERE technique. There were questions about the typical number of applications used in SERE, and whether AZ's brief "spell" was unusual, which seemed worth investigating. That winter OMS sought information directly from medical personnel in the Army and Navy SERE programs, ostensibly researching options for an Agency-run training program. Although limited by what could be discussed on the phone and slowed by travel schedules, OMS eventually learned that Agency waterboard technique differed substantially from that of the Navy program (the only one in which the waterboard was still used).

The waterboard experience was mandatory for all Navy SERE teaching and monitoring staff, but fewer than half their trainees were put on the board. Most of those who were received only a single application of 20-30 seconds, and no one had more than two applications. Water was applied primarily to the upper lip where it saturated a cloth being lowered over the nose and mouth; little if any water passed through the cloth into the mouth. The goal wasn't to "break" the students, but rather to highlight a SERE teaching point that things always could get worse; and to encourage (rather than force) reasonable countermeasures. As used within the program, the waterboard had proven to be very safe; complications among their prescreened students were extremely rare, and short-lived.

(b)(1)
(b)(3) NatSecAct

This emerging understanding coincided with the capture and initial interrogation of terrorist Khalid Shaykh Muhammed, mastermind of the 9-11 attacks, operations chief of al-Qa'ida, and unquestionably the number three man in its hierarchy. He had been captured [redacted] on March 1, [redacted] If anyone knew of imminent al-Qa'ida attacks, it was "KSM."

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

The [redacted] RMO had been [redacted] since [redacted] February, to provide general medical support to detainees the [redacted] interrogation of high value terrorist Asadullah. His intake exam of KSM revealed an obese 38-year-old, with no significant medical problems, but who was demanding and narcissistic and refused both food and liquids. Considering the rejection of fluids unsafe, the RMO administered a tap water enema, following which KSM discontinued his fast. After several days of unsuccessful interrogation (involving most measures other than confinement box and waterboard), KSM was transferred [redacted] with the RMO accompanying.

(b)(1)
(b)(3) NatSecAct

By this time OMS had begun to assemble a guide for medical personnel supporting the interrogation program, which brought together and expanded on material previously sent to the field. A working draft section on the waterboard reflected both the

experience to date and what had been learned from the Navy. One goal of this section was to insure that physicians monitoring the waterboard not be misled by previously issued SERE-based reassurances—so differences between the SERE approach and that of the Agency were spelled out in detail.

One or two applications safely given to thousands of trainees said something about risk, but AZ was the only multiple-application case known to us. He may have had a period of non-responsiveness, so a limit on the number of applications probably was in order. The provisional thinking was that, absent any emerging medical problems, 2-3 sessions of 2-3 applications per day probably was medically safe during the first 2-4 days, but that special attention probably was necessary after that. An upper limit of 20 applications in a week was considered, but as "it [was] hard to imagine an operational argument for continuing [the waterboard] after that degree of 'failed' treatments" it was thought that such a high number "may well be moot."[76]

To assist with future reviews, RMOs monitoring the waterboard were to report all waterboard sessions in detail. This was to include the length of applications, volume applied, whether water entered the naso- or oropharynx, whether a seal was achieved, and the interval between applications. About March 11th, this in-process "OMS Guidelines on Medical and Psychological Support to Detainee Interrogations" was sent informally to the RMO and PA on-site at [redacted] and th[redacted] RMO [redacted]n slated to travel there.

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

Meanwhile, KSM's interrogation had resumed not long after his transfer to [redacted] and on March 10 he was first subjected to the waterboard (5 applications). As with AZ, the interrogation was handled by psychologist/interrogators Jessen and Mitchell, and monitored by the OTS psychologist who had worked with AZ. Two days later, the waterboard again was used, but this time with an intensity far exceeding anything in the past. In five sessions spanning a 24-hour period, the waterboard was applied over 80 times, almost half lasting 20-40 seconds. OMS first learned of this from the RMO who was seeing the waterboard used for the first time. He had repeatedly re-examined KSM throughout this period and was struck by how well KSM had withstood the experience.[77]

(b)(3) CIAAct
(b)(6)

On receipt of these reports [redacted]MS went to [redacted]SM to report that OMS thought that extent of waterboard usage was both excessive and pointless. OMS also doubted that repetitive applications had a cumulative effect, as sleep deprivation unquestionably did, and later followed up with a note to CTC/LGL saying that while we believed "the unpleasantness/discomfort of the [waterboard] process indeed would persist [through multiple applications], perhaps to the point of becoming intolerable;" any detainee

(b)(3) CIAAct
(b)(6)

[76] Our expectation remained that the waterboard would prove irresistible, were information actually being withheld. Our draft text included the observation that "[i]t would appear that subjects cannot maintain psychological resistance to this technique more than a few days, at most"

[77] As precautions, the RMO had monitored KSM's blood oxygen with a pulse oximeter, and required that saline be alternated with water, to avoid water intoxication.

uncertainty about what was happening "certainly would diminish with identical repetitions of the same process—the novelty and initial shock having worn off."[78] In essence, once a detainee was aware that he could withstand the waterboard, it was just a matter of whether he wanted to continue to put up with the traumatic experience.

(b)(3) CIAAct
(b)(6)

After the [redacted] MS visit, RDG sent a cable suggesting that KSM's interrogation rely less exclusively on the waterboard. Standing sleep deprivation was begun, and intermittent water dousing. Two days later KSM again was subjected to the waterboard, though at a far reduced level. Over the following week he had a total of nine waterboard sessions, involving about 90 discrete applications, nearly half lasting 20-40 seconds. By the time the waterboard was finally discontinued, on March 24th, KSM had experienced over 180 applications, about 40% of which were at least 20 seconds long. This was twice the number of exposures experienced by AZ, and the applications had averaged twice as long (18 seconds vice 9).[79]

KSM had early developed reasonably effective countermeasures, breathing from the side of his mouth, holding his breath, and swallowing voluminous quantities of water. The interrogators dealt with this by dramatically increasing the water volume, timing applications to coincide with expiration, generating startle reflexes by splashing cold water on his chest and abdomen, holding his lips, and ultimately even creating a small reservoir of water directly over his mouth. Remarkably KSM showed no signs of a physical impact during any point in this ordeal. As with AZ, he developed a few abrasions on his lower legs struggling against the restraining belts, but this problem was remedied through adjustment of the straps and treatment of the abrasions.

When the final version of the OMS Guidelines was distributed on April 1st, it detailed appropriate medical precautions, and retained an explicit juxtaposition of the SERE waterboard technique and experience with that of the Agency. While no specific limits were set on applications per session, it was observed that as many as 25 applications probably would be safe during the first week, but thereafter only sporadic waterboard use would be acceptable.

(b)(3) CIAAct
(b)(6)

By this time OMS was convinced that the Agency had been poorly served by shallow research on the waterboard and its purported irresistibility. Additionally, OMS (and the Inspector General) heard that rather than having "extensive" experience, neither of the two psychologists/interrogators previously had used the waterboard; and that only one had even seen it in use. This was consistent with their having worked in the Air

(b)(3) CIAAct
(b)(6)

---

[78] [redacted]MS to [redacted] CTC/LGL, 28 March 2003, responding to a [redacted] cable critique of the proposed OMS Guidelines on the waterboard, which the RMO had shared with [redacted] personnel. The interrogators asserted that the waterboard had been selected specifically because it did not lose effectiveness with repetitions, and that they knew of no evidence that effectiveness was loss.

(b)(1)
(b)(3) NatSecAct

[79] In late 2006 KSM reported to the ICRC that water had been poured onto a cloth by one of the guards "so that I could not breathe" and that "[t]his obviously could only be done for one or two minutes at a time." He remembered the process being repeated for about an hour.

(b)(1)
(b)(3) NatSecAct

Force SERE program, which had not used the waterboard for years, and seemed to explain the wide disparity between their methodology (number of repetitions, length of applications, volume of water,[80] and technique) and that described to us by the Navy. In essence, the experience with AZ and KSM had been little more than an amateurish experiment, with no reason at the outset to believe it would either be safe or effective.[81]

Some within the RDG leadership agreed with OMS on this point, and with the view that the value of the waterboard was vastly overstated; others thought the waterboard was key to the success of the two most important interrogations in a dramatically successful program. In fact, after his period of enhanced interrogation, AZ was a remarkable intelligence resource. As "the professor," he provided a veritable encyclopedia of useful material. Later he attributed his cooperation to various factors, including an interrogation of such severity that it allowed him to rationalize cooperation to Allah. (He also once said he cooperated because of the medical care given "to an enemy"—like his mother would have done. He believed the medical staff at least twice had saved his life, though noted this had denied him martyrdom.)

In practice, however, AZ's cooperation did not correlate that well with his waterboard sessions. Only when questioning changed to subjects on which he had information (toward the end of waterboard usage) was he forthcoming. A psychologist/interrogator later said that waterboard use had established that AZ had no further information on imminent threats—a creative but circular justification. In retrospect OMS thought AZ probably reached the point of cooperation even prior to the August institution of "enhanced" measures—a development missed because of the narrow focus of questioning. In any event, there was no evidence that the waterboard produced time-perishable information which otherwise would have been unobtainable.[82]

KSM had proven much more resilient than his soft appearance suggested, even during the period of most intense waterboard use. He figured out early that, however unpleasant the waterboard experience, it wasn't going to get any worse, and he knew he

[80] An average of five gallons per session was used on KSM, some being splashed on his chest and abdomen. This was about five times the volume allowed in a SERE session (which also included splash, but was delivered in a single application).

[81] This OMS view was well known through it's inclusion in the final May 2004 Inspector General Report: "According to the Chief, Medical Services, OMS was neither consulted nor involved in the initial analysis of the risk and benefits of EITs, nor provided with the OTS report cited in the OLC opinion. In retrospect, based on the OLC extracts of the OTS report, OMS contends that the reported sophistication of the preliminary EIT review was exaggerated, at least as it related to the waterboard, and that the power of this EIT was appreciably overstated in the report. Furthermore, OMS contends that the expertise of the SERE psychologist/interrogators on the waterboard was probably misrepresented at the time, as the SERE waterboard experience is so different from the subsequent Agency usage as to make it almost irrelevant. Consequently, according to OMS, there was no a priori reason to believe that applying the waterboard with the frequency or intensity with which it was used by the psychologist/interrogators was either efficacious or medially safe." OMS also thought it inappropriate that the only interrogators authorized to use the waterboard were judging its effectiveness.

[82] By the time AZ's exposure to the waterboard ended, he had been in detention almost five months.

could handle that. (AZ also seemed to be aware that he wasn't going to be allowed to injure himself on the waterboard, but was more emotional about the experience.) Ultimately it was 6½ days of standing sleep deprivation (extending a day past the final use of the waterboard) that led KSM to lose his composure and begin to cooperate. Thereafter, he too became a font of useful intelligence. The extensive waterboard use conceivably contributed to this, but it did not seem so to the medical personnel. If anything, the RMO thought KSM more steeled and recalcitrant just before and after the treatments, which also provided periodic relief from his standing sleep deprivation.

An Agency Inspector General study of the detention and interrogation program was ongoing at the time of KSM's interrogation, and when issued in 2004 closely mirrored the OMS perspective. Agency waterboard use "went beyond the projected use of the technique as originally described to DoJ."[83] In all three cases "[t]he waterboard's use was accelerated after the limited application of other EITs…because the waterboard was considered by some in Agency management to be the 'silver bullet,' combined with the belief that each of the three detainees possessed perishable information about imminent threats against the United States." The IG noted that AZ did provide more intelligence after being subjected to the waterboard, but said it was unclear whether another factor was at play. "In Khalid Shaykh Muhammad's case, the waterboard was determined to be of limited effectiveness. One could conclude that sleep deprivation was effective in this case, but a definitive conclusion is hard to reach considering the lengthy sleep deprivation followed extensive use of the waterboard."[84]

Several of the OMS concerns were addressed by RDG in the months following the KSM interrogation. DoJ, senior White House officials, selected NSC principals, and the leadership of the Congressional Oversight Committees were all briefed on the Agency's "expanded" use of EITs, including the waterboard; and DoJ advised that from their perspective these deviations were not significant.[85]

In mid-May 2004, just over 13 months after the waterboard was used on KSM, the *New York Times* carried the first published reference to Agency waterboard use.[86] The context was the publication just a few weeks earlier of photos of Iraqi prisoners being abused at Abu Ghraib prison. The *Times* article, based on information from sources with imperfect knowledge (who again alleged the withholding of pain

---

[83] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 5.

[84] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 90-91. One of the SERE psychologists also had explained that the "Agency's technique is different because it is 'for real' and is more poignant and convincing." (Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 357.

[85] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 23-24.

[86] "Harsh C.I.A. Methods Cited in Top Qaeda Interrogations," *New York Times*, 13 May 2004.

medication), also correctly reported that Agency interrogation techniques were drawn from a military training program (unnamed), had been endorsed by the Justice Department, and used "graduated levels of force, including a technique known as 'water boarding.'" Less accurately, waterboarding was said to involve a prisoner being "strapped down, forcibly pushed under water and made to believe he might drown."

This article, and a June 2004 *Washington Post* article on DoJ's narrow 2002 definition of torture,[87] ushered in an avalanche of press and editorial attention to interrogation techniques, which increasingly were labeled as "torture." The waterboard quickly became the symbol of Agency torture. Within the Agency, the waterboard was recognized as being in a category by itself—being the sole EIT designated "Level 2"—but, armed with the DoJ interpretation, both the Agency and White House continued to deny that Agency detainees had been tortured. Faced with unrelenting criticism, the White House and DoJ soon announced that the August 2002 guidance was being redrafted. Pending this, the press reported, the CIA had put its harsh tactics on hold.[88]

In practice no one had been subjected to the waterboard since KSM, and no new HVD taken into custody since the spring 2004 media reports. It wasn't so much that "harsh" tactics were on hold, as that there were no new candidates for enhanced interrogation. This changed at the end of July, when Janat Gul [redacted] was transferred to Agency custody. An al-Qa'ida facilitator, Gul was believed knowledgeable about plots timed to coincide with the November 2004 Presidential Elections; he immediately was approved for a range of enhanced measures, though not the waterboard. Some senior managers still believed the waterboard might nonetheless be useful, so the Agency asked Justice to re-evaluate its use in this specific case.

(b)(1)
(b)(3) NatSecAct

On August 6, 2004 DoJ replied that they considered it "a close and difficult question," but concluded that subjecting Gul to the waterboard "outside territory subject to United States jurisdiction would not violate any United States statute..., nor would it violate the United States Constitution or any treaty obligation of the United States." This judgment was conditional on physician and psychologist pre-evaluation and continued monitoring, and—on the basis of new RDG guidance—waterboard use being limited to no more than two 2-hr waterboard sessions per day, with the total time of actual

[87] "Memo Offered Justification for Use of Torture," Washington Post, 8 June 2004. DoJ guidance had been alluded to, without specifics, as early as an 11 May 2004 *Washington Post* article, Secret World of U.S. Interrogations," and subsequently discussed in the *New York Times*, *Newsweek* and *The Wall Street Journal*. [redacted]
(b)(1)
(b)(3) NatSecAct

[88] "Document on Prison Tactics Disavowed," Associated Press, 23 June 2004; "Justice Dept. Rewrites Prison Advice, " Associated Press, 24 June 2004; "CIA Puts Harsh Tactics on Hold," *Washington Post*, 27 June 2004.

applications during the day not exceeding 20 minutes. There were to be no more than 15 days of use, during a maximized authorized period of 30 days.

(b)(3) CIAAct
(b)(6)

On seeing the DoJ memo, OMS advised RDG that the new limits still posed potential medical risks. Accordingly, [redacted] MS and [redacted] RDG jointly revised the allowable exposures downward, further reducing the number of days during which the waterboard could be used by two-thirds, and the time allowable for applications per 24-hours from 20 minutes to 12.[89] DoJ was advised of these reductions, and incorporated them into a later approval. As previously, the primary OMS area of responsibility was safety and not value or effectiveness. Neither OMS nor many in RDG believed even this reduced level was operationally necessary. In extraordinarily resistant cases, [redacted] MS believed that at most a single "warning" session of 2-3 applications—perhaps repeated once, at week later—might be tried if critical, urgent information was involved, but even then other measures would be preferable.

(b)(3) CIAAct
(b)(6)

(b)(3) CIAAct
(b)(6)

Janat Gul proved less important than hoped, so interrogators never requested to use the waterboard. Had they done so, the on-site physician likely would have barred its use. At about age 40, Gul weighed 280 pounds (at a height of 6 feet) and was sufficiently thick-necked and out-of-shape that any resulting medical emergency could not easily have been treated.[90]

The May 2004 Inspector General report, in noting the uncertainty about the effectiveness and necessity of individual EITs, formally recommended that the DDO, together with OMS, DS&T and OGC, "conduct a review of the effectiveness of each of the authorized EITs and make a determination regarding the necessity for the continued use of each, including the required scope and duration of each technique."[91] Outside representation was to be included on the review team.

An indirect response to this recommendation came in an in-depth DO review of the CIA Detainee Program completed in June 2004, which was to have included an assessment of "the effectiveness of each interrogation technique and environmental deprivation." At that time OMS advised that it did not have sufficient outcome data to make this assessment and that were the data provided there needed to be some written

[89] No more than 6 applications of ten seconds or more were to be allowed in a session, and no more than 12 total minutes of application; no more than two sessions were allowed in a 24-hour period; and no more than five days of waterboard use in the 30-day period during which the waterboard was authorized.
[90] No one in the SERE program was known to have experienced a laryngospasm, but this always was OMS' most serious concern. If needed, emergency intubation or a tracheostomy would have been very difficult in this case.
[91] Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 8

assurance that a "study" of this sort would not violate Federal law against experimenting on prisoners.[92]

(b)(3) CIAAct
(b)(6)

When the Inspector General continued to press for a study, RDG proposed in early 2005 that an internal review be undertaken by a small team composed of a senior person from the Counter Intelligence Center, the recently retired Medical Services, and possibly a psychiatrist. At the time there had been only twenty-nine enhanced interrogation cases, so the analysis—now considered "quality control" rather than human subjects research—would be rather limited. Nonetheless, insights were considered likely to emerge. "EITs consistently associated with success likely will be evident; those of questionable success also may be evident (e.g., in cases where a second EIT of more consistent success always has been concurrently present). At the least, the record will allow a more data-based assessment of the original assumptions extrapolated from the military training programs, and allow some determination as to whether the expectations regarding specific EITs in fact were realized."[93] The unstated goal was to objectively evaluate whether the waterboard had made any positive contribution to the program.

In part to undermine the notion that individual interrogation techniques could be studied, psychologist/interrogators Jessen and Mitchell provided an instructive overview of "interrogation and coercive physical pressures."[94] Refusal to provide intelligence, they wrote, "is not overcome through the use of *this physical technique* to obtain *that effect*...independent of the other forces at work. Such thinking led some people not involved in the actual process of interrogation to believe that the relative contribution of individual interrogation techniques can be teased out and quantified...." [emphasis in original] Their work as interrogators was said to be far more complicated:

> "...the choice of which physical techniques, if any, to use is driven by an individually tailored interrogation plan and by a real-time assessment of the detainee's strengths, weaknesses and reactions to what is happening. In this process, a single physical interrogation technique is almost never employed in isolation from other techniques and influence strategies, many of which are not coercive. Rather, multiple techniques are deliberately orchestrated and sequenced as a means for inducing an unwilling detainee to actively seek a solution to his current predicament, and thus work with the interrogator who has been responding in a firm, but fair and predictable way."[95]

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct
(b)(6)

[92] Memorandum for Deputy Director of Operations, "Review of CIA Detainee Program in Response to DCI Query," 30 June 2004.
[93] "Study Proposal" attached to Lotus Note, to 24 Febraury 2005.
[94] James E. Mitchell, Ph.D. and John B. Jessen, Ph.D., "Interrogation and Coercive Physical Pressures: A Quick Overview," February 2005. This apparently is a derivative of a paper prepared at the time of the June 2004 DO review, "Using Coercive Pressure in Interrogation of High Value Targets."
[95] They continue: "As in all cases of exploitation, the interrogator seeks to induce an exploitable mental state and then take advantage of the opening to further manipulate the detainee. In many cases, coercive

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct
(b)(6)

Missing from this perspective was any question about just how many elements were necessary for a successful "orchestration." The assumption was that a gifted interrogator would know best; and the implicit message was that this art form could not be objectively analyzed. Indeed, by this time their methodology was more nuanced, in stark contrast to the rapid escalation and indiscriminate repetitions of early interrogations. Still, there remained a need to look more objectively for the least intrusive way to gain cooperation.

Ultimately the Inspector General departed from the original recommendation in favor of an entirely "outside" review, by a "blue ribbon" panel of individuals of some political prominence. In the wake of Abu Ghraib, and in the context of intense media attention, suitable and willing candidates were not easily obtained. Eventually John Hamre, Deputy Defense Secretary in the Clinton Administration, and Gardner Peckham, an advisor to then House Speaker Newt Gingrich, agreed to undertake a primarily interview-based review. Without the requisite background for the previously planned technical analysis, their task became a relatively broad review of overall program effectiveness.

In separate final reports, Peckham and Hamre both endorsed the RDG program, but differed on the question of interrogation techniques. Peckham noted that the Inspector General's principal concern was the waterboard, for which it thought there were equally viable alternatives; that RDG did not consider the waterboard effective, and "contended that use of the waterboard on lesser AQ [al-Qa'ida] operatives [than AZ and KSM] would not necessarily produce more or better intelligence;" and that "OMS is candid in its discomfort with this technique." He then concluded:

> "It is possible that other techniques would be as effective as the waterboard, but that has not been demonstrated. Until it is, I believe that the waterboard should continue to be available in the EIT arsenal." [96]

Hamre was less definitive. Noting that there was no objective yardstick by which to judge EIT effectiveness, he concluded that "the data does suggest that EITs, when incorporated into a comprehensive program based on sound underlying intelligence and analysis, did provide useful intelligence products." However, "there is no objective

---

interrogation techniques are used initially to induce a sense of despair, but then discontinued when the detainee seeks to find a way out of his current predicament and becomes susceptible to other influence techniques. Interrogators then offer the detainee hope, and subsequently exploit this hope for intelligence purposes. In other words, physical techniques, if used, are most effective when employed to create an exploitable state of mind, rather than force rote compliance"

[96] Gardner Peckham to DCI Porter Goss, "Assessment of EITs Effectiveness," 2 September 2005.

independent basis to assess when EITs other than conditioning EITs [sleep deprivation, dietary manipulation] are required.[97]

The August 2004 DoJ opinion on using the waterboard on Janat Gul coincided with a much more extensive review of the legality of nearly all interrogation techniques requested by the Agency in the wake of Abu Graib and associated Presidential statements. As part of this review, Justice attorneys held extensive sessions with OMS, and requested and were provided with written OMS critiques prepared for the May 2004 Inspector General report. This DoJ review (discussed below) spanned almost a full year, and culminated in May 2005 memoranda that in essence reaffirmed their 2002 ruling (including the legality of the waterboard). Unlike 2002, this memorandum relied heavily and explicitly on OMS input, and underscored as never before an indispensable OMS role in legitimizing the program.

(b)(1)
(b)(3) NatSecAct

Within weeks of receipt of the May 2005 DOJ opinion, another possible candidate for the waterboard presented. This was Abu Faraj al-Libi [redacted] captured by the Pakistanis and transferred to the Agency in May 2005. Initially believed one of the most senior al-Qa'ida leaders, Faraj twice was subjected to periods of enhanced interrogation measures, with seemingly limited success. When the possibility of waterboard use then was raised, OMS advised RDG that it would participate only if there was real evidence that he had critical, time perishable information. This quickly led to a rumor that Medical was withdrawing support from the program, which soon reached senior Agency management. OMS (since October 2004, DB) was requested to explain the OMS position to the Agency's Director of Support (DS). DS asked whether it would be sufficient if OGC and DO assured OMS that waterboard use was warranted; the answer was no: OMS would have to hear the evidence directly.[98] A definitive impasse was never reached, however, because senior Agency management decided that in this case the waterboard was unnecessary.

(b)(3) CIAAct
(b)(6)

Faraj al-Libi probably marks the final consideration of waterboard use. With the passage of the Detainee Treatment Act of 2005, "Military Commissions Act" of 2006, and application of Common Article 3 of the Geneva Conventions, the Agency again asked DOJ for a ruling on the legality of several enhanced interrogation measures. The waterboard was not on the newly proposed list, and it is unlikely to be on any future request. The Military Commissions Act (discussed below) made illegal any interrogation techniques that caused "serious" pain and suffering (vice "severe," previously). While the case may be arguable, the waterboard may not have survived that test.[99]

---

[97] John Hamre to DCI Porter Goss, "Response to request from Director for Assessment of EIT effectiveness," 25 September 2005

[98] OMS did not think the case was there. Abu Faraj was believed once to have known the whereabouts of Osama bin Ladin and al-Zawahiri. Given his publicly announced capture many weeks before, any information he held no longer seemed perishable.

[99] A different type of waterboard discussion may continue. The three HVDs subjected to the waterboard were interviewed by the ICRC after their transfer to Guantánamo. Their stories were highlighted in the

The waterboard, despite its role as a symbol of Agency torture, did not prove as psychologically overwhelming as received SERE wisdom indicated, and it certainly was not irresistible—even in the face of a more aggressive, invasive, and potentially dangerous Agency methodology than used in SERE. It also was not intrinsically painful. There must have been physical discomfort from the occasional associated retching, but both AZ and KSM complained to the ICRC only of the pain of the restraining straps. Even the retching would have been eliminated had true SERE technique been employed. In short, the waterboard was primarily a psychological measure. That said, had the true limits of SERE use been known to OMS at the outset, its application would have been limited to a few (ineffective) applications, leaving some to believe that more applications would achieve the goal. Even very limited used may not have avoided the devastating public penalty ultimately paid by the Agency for its use.

As previously noted, an unrealistic expectation that waterboard applications would eventually "succeed" informed the DoJ guidance, and underpinned its extensive use with AZ and KSM. Though not a medical question, per se, OMS came to believe that the waterboard's impact as an interrogation tool was just the opposite. The waterboard experience was miserable but the effect not necessarily cumulative (as was sleep deprivation). Once the shock of the initial applications had passed, KSM knew what was coming and developed coping strategies; after so many applications, he also had no reason to believe anything worse was likely to follow. In essence less coercive measures were likely to produce perishable information at least as quickly. To OMS this undermined the legal justification for repetitive use.

DoJ also determined that the waterboard was legal because it was not intended to threaten death (i.e., as in a mock execution). Within OMS, this interpretation eventually was controversial. The fact that thousands of SERE trainees had safely undergone the waterboard would not be known to detainees, who in addition were in a hostile environment vice training. Setting aside interrogator intent, a *lengthy* initial application could have appeared to threaten death. In theory, a detainee would have been desensitized before this happened through applications lasting just a few seconds, which was Agency practice. Eventually, the detainee would realize that he could handle the longer applications. Additionally, most detainees quickly discerned—because of the ongoing medical attention—that there was no intent to seriously harm them. As a practical matter, all this is moot since by the time questions arose the waterboard was no longer in use. In the unlikely event that the waterboard is again considered a viable option, the question warrants further thought.

ICRC report to the Agency, which DCIA Hayden then discussed with Congressional Oversight Committees. At the time of this writing [June 2007] the Committees had ask for detailed analyses of the intelligence obtained before and after enhanced measures were employed, i.e., the question originally asked both by OMS and the Inspector General in 2003 and 2004.

HVDs,[100] EITs, and OMS Guidelines

When the OMS Guidelines in preparation at the time of KSM's interrogation were completed, CTC/LGL requested they not be released: new DCI approval would be required, and he had just issued his own guidelines. OMS countered that its guidance was consistent with that of the DCI and provided a concise source of information needed by OMS field personnel. CTC/LGL relented, so long as "draft" was added to the title. The first week in April, 2003, the 9-page "Draft OMS Guidelines on Medical and Psychological Support to Detainee Interrogations" first went to the field.

This first issued OMS Guidelines began with a short statement of the SERE origins, DoJ sanction, and the psychological underpinnings of the program, then enumerated currently used interrogation techniques ("standard" and "enhanced"). Reference points and limits were provided for ambient temperatures, noise levels, sleep deprivation, standing in shackles, and the use of the confinement box. Nearly a third of the text was devoted to the waterboard, beginning with a description which explicitly underscored the difference between Agency and SERE usage. An estimate was given of apparently safe levels of exposure—based on the limited experience to date—and a requirement levied for extensive medical documentation of any future waterboard use. Medical contraindications also were listed, including serious heart or lung disease, obstructive airway disease, and respiratory compromise from morbid obesity. Though laryngospasm had not been encountered in the SERE program OMS believed it to be the most serious theoretical risk, so continued waterboard use was barred if previous applications were associated with any hint of impending respiratory compromise, such as hoarseness, cough, wheezing, stridor, or difficulty clearing the airway. Finally, a working draft assertion, prior to KSM, that "it would appear that subjects cannot maintain…resistance…more than a few days" was replaced with the new observation that "SERE trainers are said to believe that subjects are unable to maintain psychological resistance to this technique for more than a few days, but our experience suggests otherwise."

The KSM interrogations were only the beginning of what proved to be the busiest and most productive eighteen-months in the history of the RDG program. In a period marked by the US-led invasion of Iraq (March 2003) and major terrorist bombings in Indonesia (August 2003),[101] [redacted] terrorists came into Agency hands, including [redacted] of sufficient importance to warrant extended interrogation. The experience monitoring these interrogations proved instructive and other sources of information were also explored. Detailed Ft. Bragg SERE protocols were obtained, additional conversations were held with both Army and Navy SERE psychologists, and OMS physicians and psychologists observed courses at both Ft. Bragg and San Diego. In San Diego, DC/MS even underwent the waterboard.

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

[100] Over time High Value Targets (HVTs) came to be known as High Value Detainees (HVDs)
[101] E.g., the Jakarta Marriott, killing 10 and wounding 150.

Ten new RDG detainees were interrogated between April and August 2003 with eight subjected to enhanced measures. The EIT mainstay, post-KSM, was standing sleep deprivation (lasting from one to four days), punctuated by sessions which routinely included attention slaps, walling and water dousing.[102] This approach generally achieved cooperation within a week. A few detainees were confined briefly in large and small boxes but, as with AZ and Nashiri, this added little if anything to the process and after September confinement boxes no longer were used.

In addition to cooperation, standing sleep deprivation produced the first medical complications seen in the RDG program. Several days of standing led to a slowly ascending edema of the lower legs, requiring that ankle shackles be loosened. In a few cases, the edema approached the level of the knee, in which case medical personnel required the detainee be seated, with the legs elevated, allowing alleviation of the edema while sleep deprivation continued. Occasionally, in addition to the edema a detainee developed lower limb tenderness and erythema, findings initially not easily distinguishable from cellulitis or venous thrombosis. This typically was associated with pre-existing abrasions from shackling at the time of initial rendition. At first these cases were treated with antibiotics or anticoagulants, but upon being seated detainee recovery was so fast that a thrombotic or infectious phenomenon was ruled out, and medications could be discontinued.

There was an early concern that standing detainees would fall asleep and shift excessive weight onto their arms, but this did not become an issue even after several days of standing. Overwhelmingly the detainees simply continued to stand and periodically move around a little. Those who nodded always startled themselves back awake. This resilience actually deprived them of an effective counter-measure, because had they simply allowed themselves to "collapse" their weight onto their arms, the standing would have been discontinued.[103]

In its early years—though unknown to OMS in 2003—the Agency regarded forced interrogational standing as dangerous. A widely-disseminated 1956 study asserted that the resulting edema soon led to circulatory and renal failure, and psychosis.[104]

---

[102] Water dousing (often soaking), though newly prominent among the interrogation techniques, had been addressed in the first issued OMS Guidelines. Most often water was simply splashed or hosed onto the detainee, but in the most extreme version the detainee was made to lie down on a plastic sheet, with water poured over him for 10-15 minutes. A psychologist and PA had to be present, and the room temperature at least 70°. Consistent with SERE practice, doused detainees had to be dry before being placed in spaces with ambient temperatures less than 78°. See also Office of the Inspector General, "Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003)," 7 May 2004, p. 76

[103] This suggestion is found in Agency commentary on detention as early as the 1950s.

[104] "Many men can withstand the pain of long standing, but sooner or later all men succumb to the circulatory failure it produces. After 18 to 24 hours of continuous standing, there is an accumulation of fluid in the tissues of the legs. This dependent 'edema' is produced by fluid from the blood vessels. The ankles and feet of the prisoner swell to twice their normal circumference. The edema may rise up the legs

Detainees in the RDG program provided no evidence for this belief. Their generally benign record probably is attributable to there being enough slack in the shackling to allow a little movement and the periodic breaks occasioned by sessions using other interrogation measures. In all cases, once allowed to sit (and sleep), their recovery was rapid and complete.[105]

Whether standing added anything to simple sleep deprivation was a point of some discussion. Simple sleep deprivation had not been effective during AZ's first interrogation, and later detainees at least initially all began in a standing position. The fatigue of standing presumably heightened the effect of the sleep deprivation, but to what degree remains unknown.

(b)(3) CIAAct
(b)(6)

(b)(3) CIAAct
(b)(6)

(b)(3) CIAAct
(b)(6)

OMS guidelines also increasingly addressed detainee health in the post interrogation phase. As the number of post-interrogation detainees grew, with no apparent prospect of transfer elsewhere, OMS had turned to the Federal prison system for insight into long-term prison care. In June 2003 the (b)(6) Bureau of Prisons was invited to Headquarters to discuss problems of long-term confinement, and in mid-July [redacted]MS, [redacted]MS, and [redacted]MHD (accompanied by two senior RDG officers) visited the Administrative Maximum (ADX) "supermax" facility in Florence, Colorado, which then held the twenty-two terrorists imprisoned in the Federal system. The ADX staff provided a comprehensive tour and briefing that gave a good feel for the circumstances of detention, the medical care provided, and their experience with terrorist prisoners.[106] OMS learned their protocols for dealing with hunger strikes, medical

---

as high as the middle of the thighs. The skin becomes tense and intensely painful. Large blisters develop which break and exude watery serum. The accumulation of the body fluid in the legs produces an impairment of the circulation. The heart rate increases and fainting may occur. Eventually there is a renal shutdown, and urine production ceases. The prisoner becomes thirsty, and may drink a good deal of water, which is not excreted, but adds to the edema of the legs. Men have been known to remain standing for periods as long as several days. Ultimately they usually develop a delirious state, characterized by disorientation, fear, delusions, and visual hallucinations. The psychosis is produced by a combination of circulatory impairment, lack of sleep, and uremia." "Communist Control Techniques," 2 April 1956. This was an OTS-sponsored QKHILLTOP study. This text appears almost verbatim in a published version of this article, Lawrence E. Hinkle, Jr., MD and Harold G. Wolff, MD, "Communist Interrogation and Indoctrination of 'Enemies of the States,' Analysis of Methods Used by the Communist State Policy (A Special Report), " *A.M.A. Archives of Neurology and Psychiatry* 76 (1956), pp. 134-135. [The published text read, "This dependent edema is produced by the extravasation of fluid from the blood vessels."] The latter is verbatim from an OTR/A&E Staff paper on "Brainwashing From a Psychological Viewpoint," February 1956; which began with a June 1955 study that discussed standing stress positions without the medical analysis.

[105] The 1956 study said that the KGB required prisoners to stand or otherwise hold fixed positions until it "produces excruciating pain" which the authors considered "a form of physical torture, in spite of the fact that the prisoners and KGB officers alike do not ordinarily perceive it as such." As noted, HVDs subjected to standing sleep deprivation were not in a fixed position, and did not report an associated pain.

[106] All twenty-two of these terrorists were imprisoned for activities directly tied to bombings. At an average age of 41, there were somewhat older than our population, and on average had been in prison for

complaints, and routine evaluations; and how they minimized the risk that personal effects such as spectacles and toothbrushes would be made into weapons.

Several revisions of the OMS Guidelines were prepared during the summer of 2003, culminating with a 12-page September 2003 issuance.[107] These guidelines gave guidance on responding to the recently noted complications and required detailed documentation of the circumstances of standing sleep deprivation. A new section was added on "Post-Interrogation Detention," which covered exam frequency, [108] diet and dietary supplements, height-for-weight, hunger strikes, hygiene, and examination documentation and frequency. Previous guidance on intake examinations was codified and expanded, e.g., to include laboratory studies such as CBC, Hepatitis B and C, HIV, and a chemistry panel.

Five months later, in February 2004, an expanded version of "OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation, and Detention" (18 pages, plus a 4-page appendix)[109] was issued. A Part II on "Psychological and Psychiatric Support to Detainee Interrogations" (previously discussed) also was disseminated. Among other things these Guidelines now included guidance on disruptive behavior during renditions (including the use—never required—of diazepam and haloperidol), vision problems, dental care, and more on "hunger strikes and food refusal." A newly-added appendix succinctly outlined the basis for the medical limitations on the various interrogation techniques.

This issuance also reflected a December 2003 change in CTC instructions, which reduced the upper limit of "standard" sleep deprivation from 72 hours to 48, and "enhanced" sleep deprivation from 264 hours (with an 8-hour sleep break at 180 hours) to 180 hours. This change was prompted by the first instance of a sleep-deprived detainee hallucinating.[110] In October, 55-year-old Arsala Khan—one the oldest detainees ever held—began to "see" dogs attacking his family. Khan previously had been subjected to periods of 37 and 56 hours without sleep without complications, but this hallucination came after only about 21 hours. Since none of this sleep deprivation was at "enhanced"

---

just under six years. In general they were respectful toward the staff (though regularly tested the system), but prior to transfer to Florence two-thirds had been involved in prison violence, nine had threatened prison staff, and one was suspected of murder. About a third had made suicidal gestures; 12 had initiated hunger strikes (5 were fed involuntarily by N-G tube). Extraordinarily modest, they for a long time refused recreation because of the prerequisite body search, and showered wearing underpants. With the exception of one elderly man, they were in good physical shape, and—remarkably—during psychological interviews or testing showed no diagnosable pathology.

[107] "Draft OMS Guidelines on Medical and Psychological Support to Detainee Interrogations," September 4, 2003 [12 pp]

(b)(1)
(b)(3) NatSecAct

[108] This formally corrected a significant deficit in medical documentation, [redacted] initially had a no local records policy. In practice this had been corrected in January 2003 through cable reporting.

[109] Issued 27 February 2004.

[110] The previous spring, a detainee claimed to have hallucinations, but careful psychological evaluation at the time proved this to be feigned.

levels, there was no on-site medical monitoring. When the hallucination was reported to Headquarters, further sleep deprivation was barred. Later the "standard" limit was reduced. The change in the "enhanced" upper limit also reflected the program experience that it had been unnecessary to keep anyone awake even as long as 180 hours. (Only three of some 25 detainees eventually subjected to sleep deprivation even were kept awake over 96 hours.)

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct

Providing medical and psychological coverage for both new interrogations and the growing number of widely dispersed detainees posed an increasing challenge, especially given the separate manpower demands in (b)(1)

(b)(1)
(b)(3) CIAAct
(b)(3) NatSecAct

[111] At closure (b)(1) (b)(3) NatSecAct detainees had been held there, not all at the same time:

(b)(1)
(b)(3) NatSecAct

late 2003 most physician coverage was handled by a headquarters-based physician newly assigned near-fulltime responsibility for program support. All psychological staff support was provided directly from Headquarters, as was most of the extensive demand to accompany rendition flights, including inter-facility movement. (b)(1) (b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct [redacted] However, within weeks the Supreme Court announced it woul(b)(1) consider a case which could have mandated court access to all Guantánamo-held (b)(3) NatSecAct detainees.[113] [redacted]

[redacted]
(b)(1)
(b)(3) NatSecAct

The spring 2003 briefings to the White House, NSC and Hill on the Agency's expanded use of EITS led to reassurances about the legality of and continued support for the program, which still was generating over half the reportable intelligence on al-Qa'ida. However, the national context changed abruptly a year later when shocking photographs

[113] *Rasul v. Bush*, on 29 June 2004, reversed a District Court decision, and held that the U.S. court system had the right to decide whether foreign nationals at Guantánamo were rightfully imprisoned. The case had been appealed to the Supreme Court the previous September, and the case heard on 20 April.

[redacted]
(b)(1)
(b)(3) NatSecAct

of prisoner abuse at Abu Ghraib prison in Iraq were published in April 2004.[116] The international outrage that followed prompted White House and Pentagon condemnations of the abusive practices and investigations of detainee treatment at both Abu Ghraib and Guantánamo Bay. The Agency, while not directly involved, again sought DoJ re-validation.

The request to DoJ was more reflective of caution than a desire to limit the successful RDG program, especially in view of continuing high profile terrorist attacks. In March 2004 the Madrid bombings killed 191 and in May the first of a series of nine gruesome beheadings took place in Iraq. Each of the latter cases, which extended until October, followed the same gruesome pattern: a terrorist kidnapping, followed by impossible demands, videoed pleas from the victim, and soon thereafter a beheading, the video of which was released to the media.

(b)(1)
(b)(3) NatSecAct

About June 2004 senior al-Qa'ida operative Janat Gul was captured by [redacted] later transferred to the RDG program, prompting Agency requests for a new ruling on several EITs. In response to specific questions, DoJ affirmed the legality of dietary manipulation, nudity, water dousing, abdominal slap—all not previously specifically addressed—and the waterboard. In each instance, these were held not to violate U.S. law, the Constitution, or any treaty obligation.[117] As previously, use was explicitly preconditioned on medical and psychological evaluation and the presence of on-site medical monitoring. It was these approvals that led to the OMS-RDG discussions that further limited the extent of allowable waterboard use (previously discussed). Gul's interrogation—like others post-KSM—relied heavily on sleep deprivation, which for the second (and final) time in the program was associated with a hallucination. On the fifth day without sleep, Gul began to hear voices. Medical personnel intervened, and he was allowed to sleep, which ended the symptoms.

At the end of 2004, OMS issued a new expanded version (27 pages + 7-page appendix) of its Guidelines. Unexpectedly, this particular version of the Guidelines became a foundation of the next issued DoJ opinions (in May 2005) on the legality of enhanced interrogation techniques. Among other changes, the December 2004 version reflected a summer 2004 RDG decision to abandon the previous distinction between "standard" and "enhanced" interrogation techniques; there now was a single listing of approvable techniques. Additionally, the Guidelines followed RDG in listing some interrogation techniques separately as "conditions of confinement." These included such things as diapering/nudity, shaving, white noise, and continuous light or darkness. Exposure to "cool environments"–previously listed, but never used—was dropped

(b)(1)
(b)(3) NatSecAct

[117] DoJ to John Rizzo, Acting General Counsel, 6 August 2004; DoJ to John Rizzo, Acting General Counsel, 26 August 2004.

altogether. Other revisions incorporated the new limits on waterboard use, expanded the discussions of sleep deprivation and recovery, and specified immunization protocols.

The new Guidelines also reflected some insights gained when OMS psychologists began attending conferences of the National Commission on Correctional Health Care (NCCHC) in the summer of 2004. These included a section on "restraint and sedation of violent detainees"—which fortunately never had any application within the RDG setting. Finally, new references were provided, including the Federal Bureau of Prisons website (which had clinical practice guidelines), the NCCHC's regularly issued *Standards for Health Service in Prisons,* and Michael Puisis, *Clinical Practice in Correctional Medicine* (1998).

An issue of recurring concern was how to deal with a detainee medical emergency. (b)(1)
(b)(3) NatSecAct
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

[118] "OMS Guidelines on Medical and Psychological Support to Detainee Renditions, Interrogation, and Detention," September 2005 [29 pp + 7 pp appendix]

Problems of Detention

(b)(1)
(b)(3) NatSecAct

By 2007 a total of 97 detainees had been part of the RDG program. Prior to RDG assuming control, [redacted][119] About half the 97 RDG detainees came into Agency hands in 2003, and a fourth in 2004. In the final two years prior to the transfer of remaining detainees to Guantánamo Bay in September 2006, only 5-6 new detainees entered the program, with only two subjected to enhanced measures.

(b)(1)
(b)(3) NatSecAct

When possible, RDG arranged to transfer detainees no longer of intelligence value to the U.S. military, or render them to another country. Despite new arrivals, this effort reduced the total number of detainees in Agency control from [redacted] at end of 2003, to just [redacted] in the spring of 2004, and just [redacted] at the beginning of 2005. This figure remained relatively constant for the next year, until an accelerated effort during 2006 reduced the number remaining for transfer to Guantánamo to 14.

(b)(1)
(b)(3) NatSecAct

Viewed differently, about 2/3 of detainees coming into Agency hands prior to October 2004 had been transferred out by circa the end of 2004; their detentions had ranged from a month to almost two years, probably averaging not much more than a year. A large majority of the detainees *not* transferred out of Agency hands by the end of 2004 continued to be held for almost two more years. Their overall detention probably averaged about three years, and as true long-term detainees they presented a different set of medical challenges.

OMS thought of the detainee experience as divided into three phases: rendition and initial interrogation, sustained debriefing, and long-term detention. With the first two phases typically lasting only a few weeks to a few months, by far the greatest amount of a detainee's time was spent simply in detention.[120] With the sharp late-2004 decline in new arrivals, the medical role thus became almost exclusively attending to long-term detainees.

Agency detainees were, as a group, basically young and healthy. Given bi-monthly or quarterly medical check ups (more often if indicated), a healthful diet, vitamins, vaccines, adequate rest, and some opportunity to exercise, most eventually were in better shape than when they came into Agency custody. Some were even willing to comment that they looked fitter than they had in years.

[redacted]
(b)(1)
(b)(3) NatSecAct

[120] RDG characterized things similarly: an interrogation/exploitation phase lasted 1-10 weeks, with the most intense period rarely exceeding two weeks; a second, transition phase usually lasting two to three months during which the detainees cooperation was validated; and a third, debriefing phase which lasted from two to several months and in rare cases—such as AZ—for as long as three years.

(b)(1)
(b)(3) NatSecAct

A few detainees arrived with existing injuries, though none in as serious condition as AZ. Ahmed Guleed [redacted] had sustained a GSW several months prior to capture, and arrived at [redacted] with a colostomy and frozen left elbow. Two detainees arrived [redacted] with malleolar fractures sustained jumping from a high wall. Another detainee arrived with a broken finger. All required follow-up care and none were subjected to stressful interrogation either initially or later. The fracture group soon was transferred elsewhere, but Guleed's colostomy was successfully maintained for over two years before circumstances allowed a revision to be arranged. In the interim, he received professional guidance on physical therapy to restore motion in his left elbow.

Medically, of the nearly 100 detainees evaluated, none was HIV-positive, only three were hepatitis B and two hepatitis C antigen positive. One arrived with a sexually-transmitted disease—a chancroid—inflicted, he said, by a genii (djin). Most complaints while in detention were for relatively minor ailments, such as headaches, mild musculo-skeletal symptoms, rashes, gastrointestinal upsets, or an occasional pharyngitis. Eventually a few dental problems arose, treated by an RDG contract dentist who from early 2004 periodically flew to detention sites to provide both routine and focused care. Only a single dental emergency arose, in 2006, [redacted] Basic vision checks were performed by OMS personnel, and prison-safe glasses obtained. AZ initially preferred to wear a patch over his left eye socket, but eventually requested an artificial eye; this was obtained, a near perfect match to his good eye.

Over time, non-emergency issues arose which required capabilities beyond that available at the detention sites. Guleed's colostomy needed to be reversed; Gul [redacted] needed a biopsy for an enlarging thyroid; al-Hasawi [redacted] had hemorrhoids and a rectal prolapse; three detainees required endoscopy for GERD symptoms; and liver biopsies were indicated for those with chronic hepatitis B or C.

OMS once hoped the Department of Defense could provide this specialized care. When several detainees were transferred to [redacted] Guantánamo Bay in early 2004, a test case presented. [redacted]

(b)(1)
(b)(3) NatSecAct

As this concern was being addressed, the issue became moot. The pending Supreme Court decision that could have mandated access to all Guantánamo detainees led to the closure [redacted]

(b)(1)
(b)(3) NatSecAct

[redacted]
(b)(1)
(b)(3) NatSecAct

While pursuing the DOD option, RDG and OMS also evaluated over a dozen third-country alternatives. A combination of substandard medical care and/or concerns about media exposure and internal politics had ruled out all of those initially considered.

[redacted]
(b)(1)
(b)(3) NatSecAct

Attending to the psychological well-being of detainees was at least as challenging as dealing with their physical needs. The impact of sustained isolation was the primary problem and proved more psychologically challenging than had the interrogations. By design, no contact with other detainees was allowed in Agency detention facilities and continuous white noise prevented them from hearing one another. Though physically comparable to modern U.S. prisons [redacted] (b)(1) the detainee cells nonetheless were small and windowless. (b)(3) NatSecAct

[121] On the basis of blood tests, three of the detainees, including the subject with rectal prolapse once were considered candidates for liver biopsy. Of these, one declined to be biopsied, one was transferred [redacted] before a biopsy could be arranged, and further testing of the third eliminated the need.

(b)(1)
(b)(3) NatSecAct

Initially, of course, detainees had weeks and sometimes months of frequent, often intense contact with Agency interrogators and debriefers. But as this phase ended, detainees eventually were left without the intellectual stimulation such contact afforded. Initial attempts to fill this void included "homework" (even when no intelligence requirement existed), the provision of books and other reading material, and mandatory staff contacts. At the extreme, KSM was invited to present staff lectures on various subjects.

[redacted]
(b)(1)
(b)(3) NatSecAct

OMS concerns about the effects of long-term detention led to an acceleration of RDG efforts to provide more stimulation to the detainees. (These concerns were shared by RDG personnel working directly with the detainees, and by D/NCS, former Chief of CTC). This included the provision of videos and games (eventually including hand-held computer games), and the implementation of "social" or "rapport-building" sessions, during which staffers might play cards or other games with a detainee or hold informal philosophical discussions. In this setting, many detainees came to view some of the staff, even prior interrogators, as their "friends."

[redacted]
(b)(1)
(b)(3) NatSecAct

Throughout the years of the RDG program OMS psychologists and psychiatrists made at least quarterly trips to each facility, and conducted extensive interviews with every detainee. Notably, in view of the terrorist behavior, at intake no detainee had a diagnosable mental disorder, not excepting such Axis II disorders as anti-social

[redacted]
(b)(1)
(b)(3) NatSecAct

personality.[123] (This was consistent with the findings on terrorists held in the Federal prison system.) Some eventually developed adjustment problems, and at least two requested and were provided with anti-depressants. Another asked for Prozac, which he had taken previously, and was sure it would make him feel better. It didn't, so the Prozac was discontinued. Particular effort was made to identify signs of post-traumatic stress disorder (PTSD). Notably, even among those subjected to the most intense coercive measures, there were no indications of the emergence of PTSD.

OMS practice regarding the treatment of detainees who were having difficulties with their situation was to work with RDG to ameliorate conditions as much as possible within security bounds. Although at times CTC managers were frustrated by OMS unwillingness to involuntarily medicate detainees who were "acting out," medications were offered only for bona fide medical indications and with the prior consent of the detainee. This mirrored the Federal Bureau of Prisons policy on involuntary medication.

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

At least two detainees did appear to feign mental illnesses. One, [redacted] was concerned that [redacted] guards would learn of his links [redacted] He suddenly stopped speaking and isolated himself from the others in his group cell [redacted] However, he remained visibly attuned to everything going on around him, and was appropriately attentive to his activities of daily living. When he was discretely reassured that his "secret" was safe with us, he suddenly was able to express appreciation. On transfer to an entirely U.S. manned facility, his symptoms cleared.

(b)(1)
(b)(3) NatSecAct

The second case was Firas al-Yemeni [redacted] who once had passed a kidney stone. He began hoarding medications, self-inducing vomiting, defecating on the floor and crawling through his feces. At times he appeared to fake his symptoms, and his endoscopy had been normal. The best judgment was that most of his symptoms were either psychosomatic or factitious. Eventually he was transferred out of the RDG program, and his medical care assumed by the recipient country.

From the time of AZ's capture there was concern that a martydom-oriented detainee would deliberately injure himself, or attempt suicide. Accordingly, all detainees were intensively monitored during their initial interrogations and had video-monitoring of their cells throughout their detention. Aside from a rare refusal to eat or drink, however, most detainees were attentive to their person health and no seriously self-destructive behavior was evident. One detainee—Majid Khan [redacted]—twice made scratches across his wrists (not requiring suturing) when he felt he was not getting enough attention

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

[123] [redacted] In 2006 author Ron Suskind reported, in a much repeated claim, that at the time of capture AZ was found to have a serious dissociative disorder, a diagnosis inferred from AZ's diaries, which were written using several personas. In reality, this was an entirely literary device, without psychiatric overtones. Ron Suskind, *The One Percent Doctrine: Deep Inside America's Pursuit of Its Enemies Since 9/11* (New York City: Simon & Shuster, 2006), pp. 95-100.

from the facility chief. Another detainee was found to woven a noose from clothe in his cell.

Fewer than five detainees ever refused food. OMS (and RDG) policy—which was based on that of the Bureau of Prisons—allowed a hunger strike to continue unless there was some apparent impact on the detainee's health, or his weight fell to less than 90% of average for height. If one of these thresholds was reached, the health risks were explained. If a detainee still continued to refuse food, he was fed through an NG tube. Tube feeding would have been accomplished involuntarily if necessary, but the few who required it were compliant and often assisted with the procedure. Typically, hunger strikes ended soon after these feedings began.

(b)(1) (b)(3) NatSecAct

One detainee, of some later notoriety, ended a hunger strike as soon as an NG tube first was laid out and lubricated. Khaled al-Masri was a German citizen [redacted], transferred to the Agency and rendered [redacted]

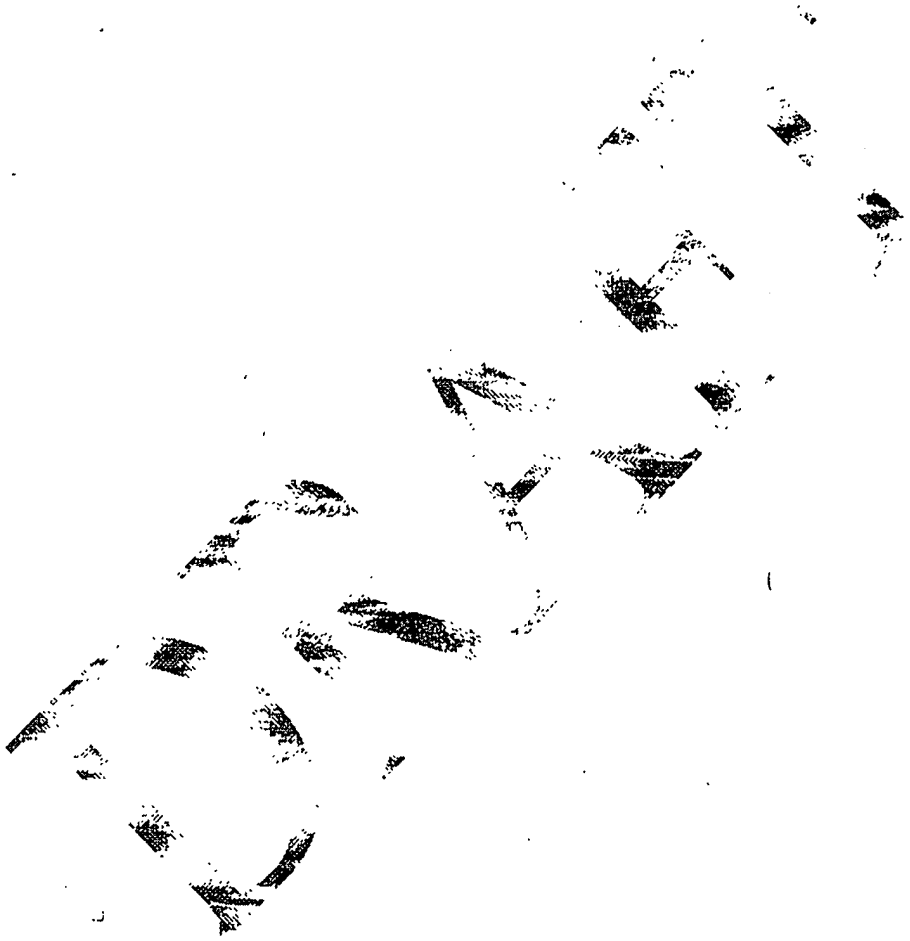
(b)(1)
(b)(3) NatSecAct

Subsequently al-Masri went public with an account embraced by the press and the ACLU, which variously alleged imprisonment [redacted] injection with drugs (including rectally), forced feeding, beatings, and sexual abuse, none of which was actually true. He had never even been interrogated, much less abused. An ACLU-supported al-Masri lawsuit against the Agency eventually was disallowed by the courts, and later he was arrested in Germany on a charge of arson—the result, his lawyer said, of a "nervous breakdown attributable to the torture he had endured in CIA custody".[124]

OMS (and Bureau of Prisons) policy on forced feedings was directly counter to that of the World Medical Association, the American Medical Association, and most medical human rights groups. These groups held that the right to patient self-determination prevailed over all other considerations. Within OMS, there was never any consideration given to allowing a detainee to starve himself to death, or otherwise kill himself. As within the Federal prison system, RDG detention facilities were carefully designed to be as suicide-proof as possible. Suicidal behavior, should it have occurred, would have been seen as a reflection of the psychiatric stresses associated with

[124] The first of scores of article on the al-Masri case was "German's Claim of Kidnapping Brings Investigation of U.S. Link," *New York Times*, 9 January 2005. His arson arrest and involuntary admission to a psychiatric ward was reported in, "German who claimed to be CIA torture victim detained on suspicion of arson," *International Herald Tribune*, 17 May 2007. A particularly trusting article, which also repeated the rectal suppository allegation, was Jane Mayer, "The Black Sites," *The New Yorker*, 13 August 2007. Mayer characterized al-Masri as "one of the more credible sources on the black-site program"

incarceration and an uncertain future. Moreover, it was clear that had a detainee managed to kill himself any commendation for the Agency commitment to self-determination would have been lost in the demands for an immediate investigation.



(b)(1)
(b)(3) NatSecAct

(b)(3) NatSecAct

~~TOP SECRET~~/ /~~NOFORN//MR~~

(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

ABC News began a series of related reports—which also won their authors a Pulitzer. These reports enumerated and briefly described six "enhanced interrogation techniques" said to be used by the Agency. Four techniques were correctly described: the attention grab, attention slap, the belly slap, and "long time standing." "Standing" for more than 40 hours, and associated sleep deprivation, was said

(b)(1)
(b)(3)
NatSecAct

~~TOP SECRET~~/ /(b)(1) /~~NOFORN~~
(b)(3) NatSecAct

to be "effective." A fifth identified technique was "the cold cell" in which a prisoner was said to be kept standing at a temperature near 50 degrees while being doused with cold water. This claim was only partially correct: standing and dousing were done, but not in a cold room. The sixth identified technique was the previously reported "water boarding," though now described as binding the detainee to a board, wrapping cellophane around his face, and then pouring on water.

This waterboard treatment was said to result in "almost instant pleas to bring the treatment to a halt." Ibn Shaykh al Libbi was said to have been broken by it after two weeks of progressively harsher techniques had failed. CIA officers subjected to the waterboard during trainings were said to last an average of 14 seconds. AZ began cooperating after 31 seconds, while KSM had impressed interrogators by lasting between 2 and 2½ minutes.

All but one of the 12 high value targets held to date were said to have required waterboarding. The exception was Ramzi bin al-Shibh, who reportedly broke down after walking past the cell in which KSM was held. [redacted]

(b)(1)
(b)(3)
NatSecAct

Despite the Pulitzer, and the frequency with which other media sources repeated ABC claims, at best they again reflected poor guesswork by sources with no direct knowledge of the program. There never was a "cold room" technique. Cellophane was never part of the waterboard.[134] Only three (not eleven) detainees had been on the waterboard. Shaykh al Libbi never was on the waterboard. Neither AZ nor KSM "broke" on the waterboard. While AZ once had water applied for 30 seconds, KSM never had an application exceeding 40 seconds. [redacted]

(b)(1)
(b)(3) NatSecAct

[133] "CIA's Harsh Interrogation Techniques Described," ABCNews, 18 November 2005.

[134] Misreporting about the waterboard was common. For at least a year after first reporting of waterbaord use, the *New York Times* described it as involving literal submersion under water. The first to correctly characterize the technique was *Newsweek*. Eventually the *Chicago Tribune* carried the rather detailed description by a Navy SEAL who had experienced the technique himself, and who also reflected conventional SERE wisdom in saying it was "instantly effective on 100 percent of Navy SEALs." See "A Tortured Debate," *Newsweek*, 21 June 2004; "The Debate Over Torture," *Newsweek*, 21 November 2005; "Spilling Al Qaeda's Secrets," *Chicago Tribune*, 28 December 2005

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

Khaled al-Masri—whose allegations of drugging, torture, and forced feeding were all fabricated—(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

Beyond the fiscal costs, these closures and resulting moves took a visible toll on the detainees. For them, movement was very stressful because of the associated uncertainties. Attending medical personnel generally talked detainees through this process, emphasizing that the change was not a reflection on their behavior (i.e., it wasn't punitive), but rather was compelled by outside factors. Nonetheless, the associated anxiety often triggered some depression, occasionally requiring treatment. The Agency later was faulted for subjecting detainees to multiple moves, but this was not by design. Had circumstances allowed, most detainees would have gone from an initial interrogation/debriefing site, to a final-long term detention facility. Detainees of lesser value would have been turned over to the DoD or returned to their home country.

(b)(1)
(b)(3) NatSecAct

Ethics

One group energized by media exposés and human rights reports were those concerned with the ethics of medical participation in detainee programs, including the role of psychologists. In the 18-month period from July 2004 to December 2005, the *New England Journal of Medicine* carried five different articles touching on the subject, ranging from "Doctors and Torture" to "Glimpses of Guantanamo—Medical Ethics and the War on Terror."[141] A particularly pointed article under the principal authorship of the president of Physicians for Human Rights also appeared in *JAMA* on "Coercive U.S. Interrogation Policies: A Challenge to Medical Ethics" (September 2005).[142]

The thrust of these articles—most of which were focused on the more visible and widely-reported practices of U.S. military personnel—was that there was little or no place for medical personnel or psychologists in interrogations, and especially those involving coercive techniques or designed with medical input on detainee vulnerabilities.[143] The interrogation techniques widely reported in the press violated the patient-centric ethic which should govern all medical practice. If not outright torture, the interrogation techniques were cruel, inhuman and degrading, and thus illegal under international and "humanitarian" law.

In general OMS personnel long since had resolved personal ethical concerns by the time such commentaries appeared in 2004 and 2005. The Office believed ethical considerations were entirely personal, so from the outset made participation in the RDG program voluntary. Withdrawal without penalty was allowed at any time. The 2002 DoJ guidance was the foundation of most decisions to become involved, but program experience reinforced the initial commitment. With the exception of the waterboard—last used in March 2003, and by late 2004 unlikely to be used again—the actual

[141] Robert J. Lifton, MD, "Doctors and Torture," *NEJM* 351(5):415-416 (29 July 2004); M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *NEJM* 352(1):3-6 (6 January 2005); George Annas, JD, MPH, "Unspeakably Cruel—Torture, Medical Ethics, and the Law," NEJM 352(20):2127-2131 (19 May 2005); M. Gregg Bloche, MD, JD and Jonathan H. Marks, "Doctors and Interrogators at Guantanamo Bay," *NEJM* 353(1):6-8 (7 July 2005); Susan Okie, MD, "Glimpses of Guantanamo—Medical Ethics and the War on Terror," *NEJM* 353(24):2529-2534 (15 December 2005).

[142] Leonard Rubenstein, JD, Christian Pross, MD, Frank Davidoff, MD, and Vincent Iacopino, MD, PhD, "Coercive U.S. Interrogation Policies: A Challenge to Medical Ethics," *JAMA* 294(12):1544-1549 (28 September 2005); also of note was Steven H. Miles, MD, ""Abu Ghraib: its legacy for military medicine," *The Lancet* 364:725-729 (25 August 2004). Miles later expanded his piece into a book-length treatment, in Stephen H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006)

[143] Much of this attention was triggered by a June 2004 *New York Times* account of the use of Behavioral Science Consultation Teams (BSCT, or "biscuits") to facilitate interrogations at Guantánamo. Biscuits were composed of a psychiatrist, psychologist, and medical assistant, who studied detainee records, including medical records, to develop effective interrogation strategies. Critics held that this violated patient confidentiality; some believed the medical personnel should not be involved, even without access to individual records. Though declining a recommendation to do away with these teams, the Pentagon did eliminate their access to the medical files.

application of enhanced techniques had been much more modest than the press image, and reassuringly free of enduring physical or psychological effects. Collectively, these techniques had been dramatically successful in producing indispensable intelligence not otherwise obtainable. Though often discounted in the press, the information that flowed out of detainee interrogations and debriefings had led to the capture of other key al-Qa'ida players and the disruption of several planned attacks. Lives unquestionably were saved.

The summer 2004 articles which launched the ethical discussion in the U.S. also clashed jarringly with an ongoing series of al-Qa'ida kidnapping and beheadings. In contrast to what seemed a sometimes utopian ethicist view, medical personnel saw themselves as living within a very real and dangerous world, fulfilling a societal obligation to support the legal, safe, and effective measures that were necessary to combat just such horrors. The role assigned to medical personnel combined the societal obligation with a responsibility for patient well-being.[144] The medical presence reflected a government commitment to the fundamental well-being of the detainee, while not allowing this commitment to preclude the acquisition of important, time-perishable intelligence not otherwise obtainable. The limits medical personnel set, and interventions made, allowed for the acquisition of the greatest possible information without placing the detainee at medical risk. In combination with RDG's tightly circumscribed policies on coercive measures, medical monitoring spared almost all detainees from experiencing more than a very time-limited period of discomfort.

In the continued ethical reiterations of 2005, some tacit acknowledgement of the societal obligation occasionally was implied, but only to be immediately discounted because some empirical "evidence" eliminated any potential ethical conflict. Both ethicists and the press regularly asserted that coercive measures were ineffective if not counterproductive, and produced serious and long-lasting physical and psychological aftereffects. More pointedly, the presence of medical personnel during interrogations was said to embolden the interrogators and lessen their restraints, thus placing interrogates at greater, not lesser risk. At worst, any physician present risked being co-opted, or socialized into a Nazi mentality.[145]

However much such "facts" simplified the ethicist's case, the OMS empirical experience was just the opposite. Invaluable intelligence resulted, medical and psychological aftereffects were not evident, and the presence of medical personnel unquestionably moderated interrogations and led to more benign interrogation guidelines. Medical autonomy also was preserved, with OMS personnel answering professionally only to OMS. Medical personnel were allowed to provide care to detainees even under

[144] Analogous dual physician roles are seen in forensic psychiatry, and occupational and public health, in which the public good sometimes overrides patient preferences.
[145] Rubenstein et al, "Coercive U.S. Interrogation Policies."

interrogation, in a professional and humane manner; and no one ever was asked to use medical expertise against a detainee, or to withhold treatment.

Finally, the carefully managed, selectively targeted Agency approach to interrogation had almost nothing in common with the excesses, program laxity, and indiscriminate focus alleged at Abu Ghraib and Guantánamo. From the outset, the RDG program was tightly circumscribed and carefully monitored, and quickly corrected problems encountered in the formative months. Almost from the outset, all interrogators, debriefers, guards, and medical personnel were prescreened, trained, guided both orally and in writing, and then monitored throughout their involvement with detainees. Despite its press image, this was a very carefully controlled program.

Program details—beyond that asserted in the media—were, of course, unknown to medical ethicists, but even with a more accurate understanding they likely would have reached the same conclusions. This was not necessarily the OMS expectation when the first medical ethics articles appeared in 2004. Unaware just how disproportionate had become the ethicists' commitments to the patient vis-a-vis society, there was some passing frustration at the mindset that casually equated mild to modest measures (e.g., limited sleep deprivation, or feeding through an NG tube) with sadistic, potentially lethal physical violence. All were torture or tantamount to it.[146] Much more useful would have been thoughtful, medically informed recommendations to help balance the acceptable degrees of coercion against the immediacy and gravity of an avoidable terrorist threat.

Ethicist views were anchored in "international" and "humanitarian" legal standards and professional declarations dating to the mid-1970s. Until the Administration's 2002 determination that al-Qa'ida terrorists were not legal combatants and thus not protected by Geneva Conventions, Common Article 3 of the Geneva Conventions provided a solid legal cornerstone for the ethicist position. Common Article 3 prohibited "at any time and in any place whatsoever: violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; outrages upon personal dignity, in particular humiliating and degrading treatment." A prohibition against cruel, humiliating or degrading treatment, or outrages on personal dignity could be and were used to cover a very wide range of interrogation measures.

Absent Common Article 3, there still was the UN Convention Against Torture, which as ratified by the U.S. barred the "intentional infliction of severe physical or mental pain and suffering." This was a much higher threshold, more genuinely consistent with what popularly would have been deemed torture. However, this too had been further circumscribed by DoJ's determination that "severe" pain was akin to that accompanying serious physical injury or organ failure, and that severe mental harm must last "months or years."

[146] Medical ethicists and the critical press were not the only ones to take this view. Even some who advocated the use of what the Agency viewed as coercive interrogation referred to it as justifiable "torture."

Further, along with railing at the Administration's permissive interpretations and asserting a humanitarian obligation to follow the Geneva Accords even if they were not legally binding, ethicists turned to another potentially valuable ally to carry their case—the professional associations of organized medicine.

The acknowledged foundational guidance on physicians and interrogation was issued in 1975 by the World Medical Association (WMA)[147] in response to questions about physician responsibilities in coercive interrogations of Northern Ireland militants. The WMA's "Declaration of Tokyo" held that physicians should not "countenance, condone or participate in the practice of torture[148] or other forms of cruel, inhuman or degrading procedures," nor "provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment." Doctors were not to be present "during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened." In short, "the doctor's fundamental role is to alleviate the distress of his or her fellow-men, and no motive whether personal, collective or political shall prevail against this higher purpose." The WMA reissued this declaration in both 2005 and 2006—after the extensive press reports of 2004-2005—adding a new section stating that physicians should not "use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, *legal or illegal*, of those individuals" (emphasis added).

In 2005 the American Psychological Association also addressed "Psychological Ethics and National Security," partially in response to accusations of unethical behavior by Behavioral Science Consultation Teams (BSCT, or "biscuits") at Guantánamo Bay. These teams were comprised of a psychiatrist, a psychologist, and a medical assistant, who sought to bring the insights of behavioral science to the interrogation process. Allegedly they had used medical records to devise interrogation strategies. The APA (psychologist), without addressing any specific allegation, enumerated the "ethical obligations in national security-related work." More nuanced than guidance soon issued by medical organizations, this advised that psychologists:

--should not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment;
--do not use health care related information from an individual's medical record "to the detriment of the individual's safety and well-being";
--do not engage in behavior that violates U.S. law and may refuse for ethical

[147] The WMA was established immediately after World War II to address issues of international concern. The American Medical Association was one of many founders.
[148] Torture was defined by the WMA as "the deliberate, systematic or wanton infliction of physical or mental suffering…to force another person to yield information, to make a confession, or for any other reason."

reasons to follow laws that are unjust or that violate basic principles of human rights [but if a conflict results, they "may adhere to the requirements of the law"]

--"are sensitive to the problems inherent in mixing potentially inconsistent roles such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships"

--"may serve in various national security-related roles, such as a consultant to an interrogation, in a manner that is consistent with the Ethics Code, and when so doing...are mindful...of contexts that require special ethical consideration."

The following year an August 2006 APA resolution aligned the APA position more specifically with the United Nations Convention Against Torture, and the McCain Amendment (see following sections), but added no additional specificity to the guidance.

The American *Psychiatric* Association, though concerned over the 2005 Guantánamo reports, did not issue its own guidance for another year. In May 2006, this APA (psychiatrist) issued a "Position Statement" on "Psychiatric Participation in Interrogation of Detainees," which stated that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture." It continued, in part:

"...No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise."

Until mid-2007 OMS psychologists, given the legality of Agency practices (reaffirmed by DoJ in March 2005), saw themselves as working within the APA (psychologist) guidelines. OMS psychiatrists never were asked to monitor interrogations, though not as a matter of policy. Initially, psychologists were more available and soon they were more experienced. The APA (psychiatrist) guidelines were the more restrictive of the two, but on careful reading might still have allowed a role similar to that actually performed by OMS psychologists.

The next issued, and more categorical guidance came from the American Medical Association: "Physicians must not conduct, directly participate in, or monitor an interrogation with an intent to intervene, because this undermines the physician's role as

healer." In a modest concession to the physician's societal obligations, the statement added, "Because it is justifiable for physicians to serve in roles that serve the public interest, the AMA policy permits physicians to develop general interrogation strategies that are not coercive, but are humane and respect the right of individuals."[149]

Since medical licensure in the United States is the exclusive purview of state medical boards, professional organizations such as the AMA have no direct power to enforce their views. State boards act on ethics violations, however, so the policy statements of professional organizations do have a potential impact. Critics very early sought to bring about change at Guantánamo Bay by attacking the licensure of the supporting medical staffs. Soon after the role of BSCT teams was publicized, the *New York Times* reported that lawyers representing detainees were trying to gather doctor's names to bring ethics changes against them in their home states.[150] Failing in this effort, lawyers later targeted physician John Edmondson, commander of the Guantánamo Bay Naval Hospital. In July 2005, a complaint against Edmondson was filed with the California State Board of Medicine, which had issued his license. He was charged with "unprofessional" conduct, including having overseen the inappropriate sharing of medical data, refusal of treatment, and active and passive involvement in physical abuse. The Board declined to pursue the case on the grounds that it could take no action against a military physician practicing on a military base absent action first by the military. They also cited a recently released study by Army Surgeon General Kiley, which had not found evidence of any medical abuse of the detainees.[151]

A few weeks later—on the fourth anniversary of 9/11—131 Guantánamo Bay detainees began a hunger strike to protest the conditions of their detention and lack of due process. Of these, were involuntarily fed through naso-gastric tubes, most compliantly and within their cells.[152] (Given the small proportion of strikers artificially fed, the Navy probably followed a protocol similar to that of OMS and the Bureau of Prisons.) Physicians for Human Rights strongly protested the forced feedings, which was

[149] AMA Press release, 12 June 2006, "New AMA ethical policy opposes direct physician participation in interrogation." This position seems to reject the suggestion of some ethicists that "limit setting, as guardians of detainee health" might be an acceptable role for physicians in "legitimate interrogation." See Bloche and Marks, "When Doctors Go to War."

The only other professional association to issue medical ethical guidance on interrogations was the American Academy of Physician Assistants (AAPA). This guidance was the most sparse. In 1987 the AAPA adopted statements opposing "participation of physician assistants in…torture or inhuman treatment," and endorsing "the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians and, by nature of their dependent relationship, for physician assistants, in cases of torture or other cruel, inhuman or degrading treatment or punishment in relation to detention or imprisonment." Most recently these AAPA statements were reaffirmed in 2003.

[150] "Psychologists Warned on Role in Detention," *New York Times*, 6 July 2004.

[151] "Head of hospital at Guantanamo faces complaint," *New York Times*, 15 July 2005; "Lawyers will appeal ruling that cleared Guantanamo doctor of ethics violations," *BMJ* 331:180, 23 July 2005. An appeal to the Board also failed.

[152] Susan Okie, "Glimpses of Guantanamo—Medical Ethics and the War on Terror." By mid-October the number of strikers was down to 25.

counter to both the WMA and AMA codes of ethics and which allowed a prisoner to starve himself to death.[153] Detainee lawyers used this episode to resume their challenge to Dr. Edmondson's licensure, and in January 2006 unsuccessfully argued to a California court that in view of the forced feedings the court should compel the state medical board to act.[154]

OMS viewed state licensing board action as a potential risk. The fact of a medical presence in the Agency program was easily discerned. Almost from the beginning there had been recurring charges that Agency medical personnel withheld pain medicine from AZ, drugged some detainees during transfer, and force fed al-Masri. The first substantial discussion of this issue, however, did not come until after the fourteen remaining HVDs were transferred to Guantánamo Bay in September 2006. The ICRC interviewed all fourteen, who comprised the most important al-Qa'ida operatives captured to date and had been those most aggressively interrogated.

The detainees appear to have given the ICRC a generally accurate summary of their overall experience (albeit recalling some traumatic episodes as lasting longer than they did). Enough medical information was included for the resulting ICRC report to include a section on "Health Provision and the Role of Medical Staff." This noted the provision of medical examinations on arrival, during interrogation, and during the long subsequent detention. Treatment provided was deemed "appropriate and satisfactory," with a comment that "in two specific instances… exceptional lengths were taken to provide very high standards of medical intervention."[155] The overriding issue, however, was the medical presence during the interrogation process, a presence correctly inferred from the use of a pulse oximeter during KSM's waterboard sessions, the repeated measurement of leg circumference during standing sleep deprivation, and detainee reports that medical personnel checked them during interrogations and sometimes intervened to stop the process.

[153] In 1991, the WMA position was modified to allow the option of physician intervention once the patient became confused or lapsed into coma, but both the Bureau of Prisons and the physicians at Guantánamo Bay act far before this stage is reached. In 2006 the WMA issued a lengthy further revision of its policy statement, which concluded: "Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment." Moreover, "[i]f a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding,….[he or she] should refer the hunger striker to another physician who is willing to abide by the…refusal." World Medical Association Declaration on Hunger Strikers, as revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006.

[154] *Jurist*, 8 January 2008; for fuller coverage, The Observer, 8 January 2006, on Guardian Unlimited, accessed at http://observer.guardian.co.uk/world/story/0,16937,1681736,00.html,. Subsequently, a British activist physician again filed this same charge against Edmondson with the medical boards of the states of California and Georgia. See "Force feeding at Guantanamo breaches ethics, doctors say," *BMJ* 332:569 (11 March 2006).

[155] "ICRC Report on the Treatment of Fourteen 'High Value Detainees' in CIA Custody," February 2007.

Labeling Agency interrogations ill-treatment tantamount to torture, the ICRC judged that the Agency program did not qualify as a "lawful interrogation, [in which] a physician may be asked to provide a medical opinion, within the usual bounds of medical confidentiality, as to whether existing mental or physical health problems would preclude an individual from being questioned," or "requested to provide medical treatment to a person suffering a medical emergency during questioning." Rather, medical personnel were "ruling on the permissibility…of physical or psychological ill-treatment." Their conclusion, therefore, was that:

> "….the interrogation process is contrary to international law and the participation of health personnel in such a process is contrary to international standards of medical ethics. In the case of the alleged participation of health personnel in the detention and interrogation of the fourteen detainees, their primary purpose appears to have been to serve the interrogation process, and not the patient. Is so doing the health personnel have condoned, and participated in ill-treatment."

Like many human rights and professional medical organizations, the ICRC held the traditional formulaic view that there were three controlling principles in medical ethics: act always in the best interest of the patient, do no harm to the patient, and insure the patient's right to dignity. Had OMS assessed itself against these criteria, it would have said that during the entire post-interrogation phase of detention these principles were honored. Excepting only a handful of involuntary feedings, consent was obtained before all medical procedures—or they were not undertaken.[156] During the Agency's legally-sanction interrogations, however, the preservation of detainee dignity and "best interest" would have defeated the process, at the cost of innocent lives. Given the magnitude of the perceived terrorist threat, short periods of indignity and significant but medically safe discomfort (far short of serious, much less severe pain) seemed an ethically inconsequential price to pay to obtain the cooperation necessary to save lives. OMS nonetheless still was able to insure that no harm befell detainees while fulfilling a societal obligation that otherwise would have been impossible. There never was any question that, forced to make a choice, the preservation of lives would override the preservation of dignity.

[156] Tube feeding, while involuntary, was never forced, as the detainees always cooperated with the procedure. An intake physical examination, including appropriate blood work, also was mandatory, but after the interrogation phase detainees could decline physical exams (or elements of the exam) or laboratory studies, though almost none did. Concurrence was obtained in writing for all invasive procedures. There sometimes was a certain incongruity in asking a detainee for consent. At one point Nashiri, who at the time was manacled and closely attended by guards (because of recent acting out), laughed when the attending dentist asked his permission to pull a problem tooth: "You obviously can do anything you want," Nashiri noted. But he did give his consent.

Notably, the ICRC's report on the fourteen detainees was not immediately leaked to the press.[157] The record to date suggests that this eventually will happen, at which time advocacy groups probably will attempt to attack the licensure of some OMS physicians. There are several reasons to believe that most if not all state medical boards would deal with ethics charges much as had California:

--DoJ had provided legal sanction to the program
--the C.I.A. (like DoD) would strongly assert the legal, ethical, and appropriately circumscribed role of the medical staff
--specific individual medical responsibilities likely would remain classified
--Bureau of Prisons policy and medical personnel would be similarly implicated
--even were existing medical ethical guidance relevant, it was sufficiently imprecise that it had to be clarified in 2006, after which no enhanced interrogations took place.[158]

A greater problem than licensure per se may be the legal and professional harassment of activists hoping to end an unpopular program by driving away its medical support, in essence exploiting the government's commitment to insuring that detainees are not harmed.

In August 2007, the American Psychological Association revisited their 2005 and 2006 statements on psychologist support to interrogations, and issued much more explicit and categorical guidance. This included an "absolute prohibition for psychologists against direct or indirect participation in interrogations or in any other detainee-related operations" involving a lengthy list of techniques alleged in media reports. Most relevant were hooding, forced nakedness, stress positions, slapping or shaking, and "sensory deprivation and over-stimulation and/or sleep deprivation used in a manner that represents significant pain or suffering or in a manner that a reasonable person would judge to cause lasting harm."[159] A movement to bar psychologists altogether from interrogation facilities was not successful. By the time this was issued (see following sections), the only clearly relevant item was slapping, though standing sleep deprivation would probably have been controversial.

More problematic than barring psychologist involvement in the prohibited techniques was a requirement that APA members report any psychologist who has

[157] In spring 2007, DCIA Hayden was asked to address Congressional Oversight Committees on various charges contained in the ICRC report. In these Hayden categorically denied any medical role other than monitoring the well-being of the detainees and providing treatment when indicated.
[158] APA (psychologist) guidance was less restrictive, but even so only one such interrogation took place after it released new guidance in 2005.
[159] "Reaffirmation of the American Psychological Association Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined in the United States Code as 'Enemy Combatants,'" Resolution Adopted by APA on August 19, 2007. Among the dozen or more enumerated techniques were waterboarding, hypothermia, exposure to extreme heat or cold, and exploitation of phobias or other psychopathology.

participates in these techniques to the APA Ethics Committee, who in turn could revoke memberships and potentially jeopardize state licensure.[160] This; in essence, placed Agency psychologists in the same potentially vulnerable position as Agency physicians.

[160] "APA Rules on Interrogation Abuse," *Washington Post*, 20 August 2007; Eve Conant, "Capital Sources: Shrinks and Torture," *Newsweek* "Web Exclusive," 20 August 2007.

An Unfinished Chapter

The new DoJ policy statement on torture issued in December 2004 stated that it did not invalidate previous guidance on specific interrogation techniques. DoJ's long-awaited re-evaluation of these techniques finally was forwarded to the Agency in May 2005. Three separate memoranda were sent, all reflecting an understanding of Agency practice and experience not available in 2002—as well as insights gleaned from the voluntary waterboarding of a senior DoJ lawyer.

A foundational 10 May 2005 memoranda corrected and expanded the 2002 descriptions, then reaffirmed that the previously addressed techniques fell short of torture.[161] These were three conditioning techniques (dietary manipulation, nudity at ambient temperature of at least 68°, and sleep deprivation), five corrective techniques (attention grasp, facial hold, facial or insult slap, abdominal slap, and walling), and four coercive techniques (stress positions, water dousing, cramped confinement, and waterboard). A second 10 May 2005 memorandum expressly extended this conclusion to the combined use of these techniques.[162] The final memorandum, dated 30 May 2005, responded to an Agency IG concern in affirming that these techniques were not barred by Article 16 of the Convention Against Torture, as ratified. This barred "cruel, unusual, and inhumane treatment or punishment prohibited by the Fifth, Eighth, and Fourteenth Amendments to the Constitution." As interpreted the Fifth Amendment was of greatest relevance, and the Supreme Court standard against which treatment was to be measured was whether a techique "is so egregious, so outrageous, that it may fairly be said to shock the contemporary conscience," a judgment noted by the Court to be highly context-specific and fact-dependent.[163]

New to the 2005 guidance was an extraordinary reliance on OMS input, totally absent in 2002. The Agency General Counsel, during an early 2004 visit, had mentioned that OMS involvement now was central to the Agency's legal case. Just how important became clearer in summer OMS-DoJ discussions during which C/MS finally observed that DoJ seemed to be under the misimpression that this was an OMS program—rather than OMS supporting CTC/RDG. In acknowledging an overemphasis, DoJ nonetheless said the presence of OMS was critical to their determinations. OMS thereafter tried to remain alert to any transformation from the notion that the RDG program being acceptable in part because of OMS involvement into something that sounded more like

[161] Steven Bradbury (DoJ/OLC) to John A Rizzo, Senior Deputy General Counsel, Central Intelligence Agency "Re: Application of 18 U.S.C. 2340-2340A to Certain Techniques That May Be Used in the Interrogation of a High Value al Qaeda Detainee," 10 May 2005.

[162] "Memorandum for John Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, "Re: Application of 18 U.S.C. 2340-2340A to the Combined Use of Certain Techniques in the Interrogation of High Value al Qaeda Detainees," 10 May 2005.

[163] Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency "Re: Application of United States Obligations Under Article 16 of the Convention Against Torture to Certain Techniques that May Be Used in the Interrogation of High Value al Qaeda Detainees," 30 May 2005.

the program being acceptable because OMS said it was. The only OMS role, if and when Justice determined that any given technique was legal, was to insure the safety of the detainee—a responsibility as well shared by interrogators and other staff.

The final DoJ memoranda stated that the legitimacy of the RDG program hinged on several-OMS relevant factors: OMS autonomy within the program; OMS assurance that detainees would be adequately evaluated—physically and psychologically—prior to, during, and following any enhanced interrogations; the authority of OMS to stop or otherwise limit any ongoing interrogation, if medically indicated; and the OMS experience that to date no medically significant aftereffects had been apparent in any previously interrogated detainee. A reliance on OMS was underscored by the inclusion of multiple quotations incorporated from the latest (December 2004) issuance of OMS Guidelines, and by many references to discussions with OMS personnel. An illustrative excerpt, from the 10 May 2005 memoranda addressing interrogation techniques:

> "In addition, the involvement of medical and psychological personnel in the adaptation and application of the established SERE techniques is particularly noteworthy for purposes of our analysis. Medical personnel have been involved in imposing limitations on—and requiring changes to—certain procedures, particularly the use of the waterboard. We have had extensive meetings with the medical personnel involved in monitoring the use of these techniques. It is clear that they have carefully worked to ensure that the techniques do not result in severe physical or mental pain or suffering to the detainees.... In addition, they regularly assess both the medical literature and the experience with detainees. [FN To assist in monitoring experience with the detainees, we understand that there is regular reporting on medical and psychological experience with the use of these techniques on detainees and that there are special instructions on documenting experience with sleep deprivation and the waterboard.] OMS has specifically declared that "[m]edical officers must remain cognizant at all times of their obligation to prevent "severe physical pain or suffering" [citation omitted]. In fact, we understand that medical and psychological personnel have discontinued the use of techniques as to a particular detainee when they believed he might suffer such pain or suffering, and in certain instances, OMS medical personnel have not cleared certain detainees for some—or any—techniques based on the initial medical and psychological assessments. They have also imposed additional restrictions on the use of techniques (such as the waterboard), in order to protect the safety of detainees, thus reducing further the risk of severe pain or suffering. You [i.e., the Agency] have informed us that they will continue to have this role and authority. We assume that all interrogators understand the important role and authority of OMS personnel and will cooperate with OMS in the exercise of these duties...."

Read in totality, the final DoJ guidance made clear that the OMS role was supportive, but this lengthy paragraph still was potentially misleading, in citing the "involvement of medical and psychological personnel in the adaptation and application of the established SERE techniques." The only OMS role in the adaptation or application of SERE techniques was to place medical restrictions on the use of the techniques selected and authorized independently of OMS.

Following the summer 2004 press accounts, and prior to these DoJ memoranda, Senators John McCain (R-Ariz) and Lieberman (D-Conn) put language into an intelligence bill which barred "torture or cruel, inhuman, or degrading treatment or punishment that is prohibited by the Constitution, laws or treaties of the United States," and required a report to Congress on interrogation measures. In January, at Administration urging, this language was dropped. That spring, 2005, Democrats and Republicans debated the need for a probe of interrogation practices, but no probe resulted.

In October 2005, Senator McCain introduced an amendment to a Defense appropriation bill which again barred "cruel, inhuman, or degrading treatment or punishment"—defined as any "cruel, unusual, and inhumane treatment or punishment" prohibited by the Fifth, Eighth, and Fourteenth Amendments (applying to non-US citizens what otherwise would have pertained only to U.S. citizens). Kerry also attached an amendment to the Senate Intelligence Authorization bill requiring a report on the Agency's recently publicized Eastern European and Asian detention facilities. Ultimately both Kerry amendments failed, but the McCain amendment moved forward—ultimately without an Agency exemption sought by Vice President Cheney and DCIA Porter Goss.

The McCain amendment—subsequently known as the Detainee Treatment Act (DTA)—passed both House and Senate by large margins, and in December 2005 was signed into law. The implications of the DTA proved somewhat more limited than expected. DoJ already had ruled that Agency techniques did not reach the threshold for the "cruel, inhuman, or degrading" treatments barred by the Constitution, and a new DTA requirement that DoD interrogation guidelines be followed was applicable only to DoD facilities, and not to "secret" Agency sites. Less reassuring was the way the DTA addressed the question of legal protections for those engaged in authorized interrogations. This stated that the U.S. Government "may" pay employee costs (including legal counsel) associated with civil action or criminal prosecution, and offered as an employable defense that "a person of ordinary sense and understanding would not know the practices were unlawful."

(b)(1)
(b)(3) NatSecAct

(b)(3) NatSecAct

(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

Over several months in the spring and summer of 2006 an OMS physician escorted five detainees that required specialized evaluation or surgery to received this care. Additionally, during this period a concerted effort was made to move as many detainees as possible out of Agency hands. Of the still in RDG facilities in late February, half had been transferred elsewhere by September, with most returned to their countries of origin. As previously, OMS personnel accompanied all detainee movements.

In June, 2006, the Supreme Court ruled in *Hamden v. Rumsfeld* that the military commission system then in place at Guantánamo Bay was not legally authorized. Additionally, the Court stated that the provisions of Common Article 3 of the Geneva Conventions (on the treatment of prisoners of war) was applicable to detainees. In response to this ruling, the Administration introduced legislation that became the Military Commission Act (MCA) of 2006 (signed in October).

The MCA established a new system of military tribunals and, consistent with Common Article 3, amended the War Crimes Act of 1996 to bar not just techniques that caused "severe physical or mental pain or suffering" ("torture"), but also those which caused "severe or serious physical or mental pain or suffering" (or "cruel or inhuman treatment"). No specific techniques were addressed; rather, the President was given authority to more specifically interpret the implications of the Common Article 3 through an Executive Order.

Finally, the MCA strengthened the protections extended by the DTA to those involved in authorized interrogations prior to 30 December 2005. Employee costs incurred during any investigation or prosecution—in the U.S., abroad, or in international tribunals—would be paid by the U.S. government.

During the summer 2006, a White House decision was made to transfer to military custody at Guantánamo Bay the 14 HVDs (b)(1) (b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

With the transfer of the 14 detainees to Guantánamo,

Within a few months, a newly captured detainee was transferred Abdul Hadi al Iraqi, the designated replacement for Zarqawi as head of al-Qa'ida operations in Iraq. He had read of CIA interrogation methods, he said, and preferred just to cooperate without them. Whether or not he was truly forthcoming is unclear, but no enhanced interrogation methods were employed prior to his transfer to Guantánamo Bay in April 2007.

(b)(1)
(b)(3) NatSecAct

(b)(1)
(b)(3) NatSecAct

There they were allowed to talk with one another, some for the first time in several years, and also were interviewed by the ICRC. Each was assigned a military lawyer to help prepare for a tribunal hearing on their status as illegal combatants. Were this status established, they then faced prosecution for their terrorist acts.

To date the Agency program had passed through two almost discrete phases. The first period, from 2002 through 2004, was primarily one of multiple successful interrogations. The second period, from 2005 through 2006, was one of lengthening detentions. The character of any third period is—as of summer 2007—still uncertain. While the Agency suspended use of EITs following the December 2005 enactment of the DTA, it did not abandon the notion of playing a unique role in the interrogation of HVDs. After reviewing the overall program, the Agency sent DoJ a request to evaluate a much reduced set of proposed "enhanced" techniques, which did *not* include walling, the waterboard, confinement boxes, dousing, and stress positions. The proposed array of techniques was limited to the three established conditioning techniques: nudity, dietary manipulation, and sleep deprivation, and four of the five corrective techniques approved in 2005: facial grasp, attention grasp, abdominal slap, and facial or insult slap (but not walling). No coercive measures were included.[164] The proposed upper limit on sleep deprivation remained at 180 hours, but with a new requirement that the detainee be reassessed after 96 hours and specifically re-approved for each additional 24 hours.

OMS welcomed these changes as further limiting medical risks without appreciably weakening program effectiveness. In its view, interrogation success appeared to result primarily from the three "conditioning" techniques proposed for

[164] In contrast to the reality, a *Newsweek* "WEB EXCLUSIVE," 20 September 2005, cited Senate staffers as saying the Administration were trying to redefine the Geneva limitations to allow seven techniques: 1) induced hypothermia, 2) long periods of forced standing, 3) sleep deprivation, 4) the "attention grab" (forcefully seizing the suspect's shirt), 5) the "attention slap," 6) the "belly slap" and 7) sound and light manipulation.

retention, particularly sleep deprivation.[165] Since to date only three detainees had been kept awake beyond 96 hours (and none as long as 180 hours), the proposal was entirely consistent with ongoing practice. "Corrective" techniques also appeared to play a synergistic role, but from the medical standpoint, walling was somewhat problematic because if not handled carefully could result in head contact with the wall. It also appeared less controlled than any other technique, and infrequently required some medical intervention.[166] Elimination of all coercive measures, and walling, would appreciably simplify medical monitoring.

As previously, OMS was brought into these newest DoJ discussions, this time in the hope that a medical distinction was possible between "severe" and "serious" physical and mental suffering. Thinking this an entirely legal question, OMS declined to speculate. Ultimately, a provisional DoJ analysis found all the requested techniques legally acceptable, i.e., they did not reach the threshold of "serious" pain or suffering. A definitive ruling awaited the underlying Executive Order interpreting Common Article 3. OMS also contributed to this discussion, through a briefing for DNI Admiral Mike McConnell on medical support to the interrogation and detention program.

(b)(1)
(b)(3) NatSecAct

The President's Executive Order finally was released in mid-July 2007, prompted by the desire to interrogate a key al-Qa'ida operative, recently captured and rendered [redacted] This EO interpreted Common Article 3 as requiring "the basic necessities of life, including adequate food and water, shelter from the elements, necessary clothing, protection from extremes of heat and cold, and essential medical care." Barred were torture or other acts comparable to murder, torture, mutilation, cruel and inhuman treatment, or acts of abuse or degradation what a reasonable person would deem "beyond the bounds of human decency." Beyond these limits, enhanced measures were still allowable, as was detention without outside access. [NEED TEXT]

The Justice Department immediately followed this with concrete guidance largely unchanged from that agreed to in draft, and allowing sleep deprivation (as above), dietary manipulation, and the several requested slaps and holds. Only nudity had been changed—to diapering.

Asked about the Executive Order on NBC's "Meet the Press," Director of National Intelligence (DNI) Mike McConnell would not say exactly what would be permitted, but he did highlight—as never publicly before—the medical role in the process:

(b)(1)
(b)(3) NatSecAct

[redacted]

[166] On two occasions detainees complained of potentially walling-associated memory or hearing loss, but a detailed evaluation at the time found both to be feigned symptoms.

"...When I was in a situation where I had to sign off, as a member of the process, my name to this executive order, I sat down with those who had been trained to do it, the doctors who monitor it, understanding that no one is subjected to torture. They're, they're treated in a way that they have adequate diet, not exposed to heat or cold. They're not abused in any way. But I did understand, when exposed to the techniques, how they work and why they work, all under medical supervision."[167]

(At the time of this writing—September 2007—the only candidate to be interrogated under these new guidelines alleged the unusual combination of visual and auditory hallucinations after just over 100 hours of standing sleep deprivation. As a result, he was allowed a 16-hour sleep break, but continued to claim visual hallucinations. A thorough psychological examination at that time led to the conclusion that he was malingering. He was returned to intermittent sleep deprivation, up to the 180 limit [over 30 days], but this did not achieve compliance with interrogators.)

[167] Transcript, Mike McConnell interview on "Meet the Press," Tim Russert, Anchor, MSNBC.com, 22 July 2007. The possible interpretation that physicians were supervising the enhanced interrogations later was addressed briefly by a McConnell spokesman who clarified that McConnell said that doctors would "monitor, not supervise" interrogations, but would not clarify if this referred to physicians, or how the monitoring would be accomplished, or if this was a new requirement. Spencer Ackerman, "(Re)Call the Doctor: Physicians Involved in CIA Interrogations?," TPMMuckracker.com, 23 July 2007. Russert, like many others, wanted to know what techniques could and could not be used (especially the waterboard), but McConnell—like other Administration spokesmen—refused to specify on the grounds that this would allow training against the techniques, and "because they believe these techniques might involve torture and they don't understand them, they tend to speak to us, talk to us in very—a very candid way."

(b)(3) CIAAct

Support to the RDG program may well be the most extensive operational commitment in the history of the Office of Medical Services. It certainly was one of the most intense. During the five years from 2002 to 2007, [redacted] OMS staff officers [redacted] (b)(3) CIAAct physicians, [redacted] psychologists, [redacted] PA's, and [redacted] nurses) were directly involved in the program. These officers evaluated, monitored and provided quality care to 97 detainees variously held in ten Agency facilities. They also accompanied well over a hundred detainee transfer flights. Their guidance and presence made possible one of the most successful counter-terrorist operations in the history of the Agency.

An enumeration of the intelligence take from the dramatically successful RDG program is beyond the scope of this history. Over 8,000 intelligence reports were generated, which was half or more of all al-Qa'ida reporting during the period. Detainee-provided information led directly to the capture of other key terrorists, averted several major terrorist attacks, and became a foundation for the 9/11 postmortem analysis. Even in the face of crippling media leaks and widespread public criticism, the Agency (and Administration) remained unwilling to abandon what had proven an invaluable tool.

Whether a more circumscribed future program will prove similarly valuable remains to be seen. Even with a retained core of less aggressive but seemingly effective techniques, this may not be possible. Eventually the Administration will be pressed to state publicly that certain aggressive measures will not be used (thereby reassuring future detainees, to the detriment of the process). Crippling leaks will remain inevitable, and approved techniques—however benign—eventually will become known and again be targeted by human rights activists. This could easily lead to the elimination of all the synergistic adjuncts to sleep deprivation, and so limit sleep restriction that it rarely is effective. Additionally, publicity to date will have led to the development of effective resistance measures.[168] In short, the immediate prospects do not look promising. Taking a longer view, future terrorist use of WMDs is viewed as inevitable; and such an attack would likely lead to another reevaluation of what interrogation measures are acceptable.

When OMS again is approached on this subject, this brief history may be of some value. A few points may be worth repeating. As OMS began this chapter, it could find no comparable record of the somewhat related experiences of the Fifties, which would have been useful. Organizationally, OMS was somewhat buried at the time in a short-lived but distracting realignment with Human Resources. Operational requests regularly were addressed, but outside the paramilitary environment OMS was not then aggressively attempting to insert itself into operations. Thus, when OTS formulated its approach to detainee interrogation, there was no meaningful medical input or review—and

[168] E.g., effective countermeasures against such techniques as standing sleep deprivation were discussed within the Agency as early as the 1950s, and simply capitalize on the desire of interrogators not to inflict serious of lasting harm. Deliberate "collapse" or a sophisticated but feigned hallucination will almost guarantee a reprieve which likely will defeat the interrogation process as used to date.

interrogational excesses resulted. In hindsight it's easy—though in the operational climate, perhaps unrealistic—to say that OMS should have been more pro-active in obtaining and critiquing the relevant briefs. Once into this fast-moving program, OMS also fell short in allowing a requirement for thorough medical records to fall victim to operational expediency and the crisis of the day. While this soon was corrected, it also was avoidable. Finally, as OMS increasingly was recognized for its vital contributions, there seemed to be a risk that too much of the program's legal justification would become OMS-based. While this issue was attended to, in view of the unique ethical issues involved it was a source of continuing concern

A last word on ethics. The more proscriptive stands taken by professional organizations since 2006 will pose potential dilemmas for OMS professionals supporting detainee operations in the future. The OMS officers who previously worked in this program confronted less concrete "ethical" issues, but nonetheless involved themselves because they thought it was the right thing to do, and because of their trust and respect for those already involved. OMS may have been representative in viewing the legitimacy—i.e., ethics—of the program as dependent on it being legal, effective, safe and necessary. Necessity required solid evidence that interrogation candidates possessed critical, time-perishable information unobtainable through less aggressive alternative measures. DoJ affirmed legality. The empirical record affirmed effectiveness and, through the presence of OMS, the safety of the program. Finally, criticality and urgency each received case-by-case analysis from CTC. Though imperfect this review nonetheless limited the application of EITs to less than a third of the 97 detainees who came into Agency hands, and further limited use of the most aggressive techniques to only 5 or 6 of the highest value detainees. A criterion of "necessity" also requires that no aggressive measure be used when a lesser measure would suffice. For a variety of reasons, the program initially was ill-prepared to make this judgment, but experiences during the first year had it well on its way to a minimalist approach.

(b)(3) CIAAct
(b)(6)