

# FROM NUREMBERG TO GUANTÁNAMO: MEDICAL ETHICS THEN AND NOW<sup>†</sup>

NANCY SHERMAN\*

On October 25, 1946, three weeks after the International Military Tribunal at Nuremberg entered its verdicts, the United States established Military Tribunal I for the trial of twenty-three Nazi physicians.<sup>1</sup> The charges, delivered by Brigadier General Telford Taylor on December 9, 1946, form a seminal chapter in the history of medical ethics and, specifically, medical ethics in war. The list of noxious experiments conducted on civilians and prisons of war, and condemned by the Tribunal as war crimes and as crimes against humanity, is by now more or less familiar. That list included: high-altitude experiments; freezing experiments; malaria experiments; sulfanilamide experiments; bone, muscle, and nerve regeneration and bone transplantation experiments; sea water experiments; jaundice and spotted fever experiments; sterilization experiments; experiments with poison and with incendiary bombs.<sup>2</sup>

What remains less familiar is the moral mindset of doctors and health care workers who plied their medical skill for morally questionable uses in war. In his 1981 work, *The Nazi Doctors*, Robert Jay Lifton took up that question, interviewing doctors, many of whom for forty years continued to distance themselves psychologically from their deeds.<sup>3</sup>

The questions about moral distancing Lifton raised (though not the questions about criminal experiments) have immediate urgency for us now. Military medical doctors, psychiatrists and psychologists serve in U.S. military prisons in Guantánamo, Abu Ghraib, Kandahar, and, until very recently, in undisclosed CIA operated facilities around the world where medical ethics are again at issue. Moreover, they serve in top positions in the Pentagon, as civilian and military heads of command, who

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<sup>†</sup> This paper was first published in Nancy Sherman, *From Nuremberg to Guantánamo: Medical Ethics Then and Now*, *Dissent Magazine*, Winter 2007, available at <http://dissentmagazine/article/?article=720>.

\* Nancy Sherman is the author of *STOIC WARRIORS* (Oxford University Press 2005). She is University Professor at Georgetown University and a 2006–2007 fellow at the Woodrow Wilson International Center for Scholars. This article is adapted from a paper given at a conference, *Judgment at Nuremberg*, held at the Washington University School of Law in September 2006.

1. See Douglass O. Linder, *The Nuremberg Trials: A Chronology*, <http://www.law.umkc.edu/faculty/projects/ftrials/nuremberg/NurembergChronology.html> (last visited Apr. 8, 2007).

2. *Id.*

3. ROBERT JAY LIFTON, *THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE* (Basic Books 1986).

pass orders and regulations to military doctors in the field, and who are in charge of the health of enemy combatants, as well as U.S. soldiers. Because we recently marked the sixtieth anniversary of the judgment at Nuremberg, I want to awaken our collective memory to the ways in which doctors in war, even in a war very different from the one the Nazis fought, can insulate themselves from their moral and professional consciences.

Lifton's research is, in part, a follow-up study. It is about the conflict and moral residue that linger close to a half a century later. The follow-up story of the medical and mental health personnel who are part of the Guantánamo detention center has not yet been told. The detention center is still in operation; and, five years after its erection, there have been no trials of doctors and no charges have been filed. It is also not clear that there should be charges and trials. But, the absence of any such spotlight makes it even more imperative that we sketch the current involvement of doctors and health workers in the operation of the Guantánamo detention center with the goal of shedding some light on their professional roles as well as on the psychological distancing mechanisms at work.

In October 2005, upon invitation, I visited the Guantánamo detention center with a small group of civilian psychiatrists and psychologists, military doctors, and Department of Defense (DOD) civilian health affairs officials, to observe detainee medical and mental health care. Among the unspoken reasons for the invitation was a steep rise in hunger strikes in mid-June 2005,<sup>4</sup> as well as bruising criticism the Bush administration had received, over that summer and fall, for its use of psychiatrists and psychologists in interrogation procedures.<sup>5</sup> More specifically, there were well-publicized allegations that "resilience training" for our own soldiers at Fort Bragg was "reverse engineered" at Guantánamo for the infliction of torture.<sup>6</sup> There were also reports of the breach of confidential psychiatric

4. For a good review of the timeline, see Tim Golden, *The Battle for Guantánamo*, N.Y. TIMES, Sept. 17, 2006 (Magazine), § 6. In conversations with the DOD organizers of my trip, hunger striking was specifically mentioned as one of their prime concerns.

5. See Jonathan Marks, *Doctors of Interrogation*, HASTINGS CTR. REPORT 17 (July–Aug. 2005); Neil Lewis, *Red Cross Finds Detainee Abuse in Guantánamo*, N.Y. TIMES, Nov. 30, 2004, at A1; Leonard Rubenstein, et al., *Coercive US Interrogation Policies: A Challenge to Medical Ethics*, 294 JAMA 1544 (2005); Neil Lewis, *Psychologists Warned on Role in Detentions*, N.Y. TIMES, July 6, 2005, at A14. An article in the *New England Journal of Medicine* on medical ethics violations in interrogation, Gregg Bloche and Jonathan Marks, *Doctors and Interrogators at Guantánamo Bay*, 353 NEW ENG. J. MED. 6 (2005), provoked an immediate DOD response before the House Armed Services Committee on July 12, 2005. See also Greg Bloche and Jonathan Marks, *When Doctors Go to War*, 352 NEW ENG. J. MED 3 (2005); Robert Jay Lifton, *Doctors and Torture*, 351 NEW ENG. J. MED 415 (2004).

6. See Jane Mayer, *The Experiment*, THE NEW YORKER, July 11, 2005, at 60–71; Greg Bloche

records used in tailoring interrogation tactics.<sup>7</sup> And, there was concern about the large-scale force-feeding of hunger strikers through stomach tubes.<sup>8</sup>

Though we were invited as observers, we did not see any of the 505 inmates throughout the day, except for a single stolen glimpse of two bearded prisoners, wearing white tunics and loose pants, who were behind screens and barbed wire. Still, two scenes involving inmates made my moral worries concrete.

Seven detainees were still on a hunger strike—a steep drop from the escalated numbers over the summer.<sup>9</sup> We were assured that the hunger strikers were being treated humanely. The commanding doctor at the time, Captain John Edmonson, showed our group (which included U.S. Surgeon General Richard Carmona, Army Surgeon General Kevin Kiley, Joint Staff Surgeon Joseph Kelly, as well as top civilian physicians who work for Undersecretary of Defense for Health Affairs William Winkenwerder) a tube used for feeding—a thin nasogastric tube, a 10-French Dobhoff—and explained that lubrication and anesthesia were routinely used before insertion. The senior military and civilian doctors listened attentively as they were told that there was overall “compliance” in that most strikers did not forcibly resist insertion of the tubes nor remove them once they were in place. Not one doctor asked about the consequences of not acquiescing to the tube; none openly worried that acquiescence might not be the same thing as consent; none voiced the concern that pulling out a nose tube funneled down the back of one’s throat to the top of one’s stomach might, in some circumstances, be painful, and that failure to do that might, at best, be a weak form of consent.

The scene is disturbing in light of reports confirmed just four months after my visit,<sup>10</sup> that detainees on hunger-strikes had been strapped into

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& Jonathan Marks, Op-Ed, *Doing Onto Others as They Did onto Us*, N.Y. TIMES, Nov. 14, 2005, at A21.

7. On the report of breaches of medical records (including exploitation of a detainee’s phobia of dogs and longing for his mother), see Neil Lewis, *Interrogators Cite Doctors’ Aid at Guantánamo*, N.Y. TIMES, June 24, 2005, at A1.

8. See Clive Stafford Smith, *Gitmo’s Hunger Strikers*, THE NATION, Oct. 17, 2005, at 8. See also *The Kojo Nnamdi Show: Guantánamo Force Feeding* (WAMU 88.5 March 13, 2006) (transcript on file with the *Washington University Global Studies Law Review*). I also learned about the force feeding from Marc Falkoff, counsel for Guantánamo detainees at the litigation offices of Covington & Burling LLP.

9. For estimates of the numbers over the summer, see *supra* note 8, and Golden, *supra* note 4.

10. See Tim Golden and Eric Schmitt, *Force-Feeding at Guantánamo Is Now Acknowledged*, N.Y. TIMES, Feb. 22, 2006, § A. The commander, General Bantz J. Craddock, head of the United States Southern Command, said “soldiers at Guantánamo began strapping some of the detainees into

restraint chairs during and immediately after force-feeding in order to prevent, according to officials,<sup>11</sup> purging and asphyxiation that might result from being fed in a prostrate position. Some detainees alleged that, while in the chair, they were force-fed not only nutrients but also diuretics and laxatives.<sup>12</sup> The result was that they urinated and defecated on themselves. The allegations raise serious questions about the role of doctors in authorizing the procedure. If diuretics and laxatives were used, who approved their use? I raised this question with a senior medical official in the Pentagon. I have not received an answer.

A second scene has also returned to me often. We were taken to the psychiatric wing of the hospital and introduced to two young female army psychiatrists. The presiding commander of Guantánamo at the time, General Jay W. Hood, praised them highly for their dedication in the face of resistance from detainees.

Five months later, I replayed that scene as I listened to the account of Joshua Colangelo-Bryan, a detainee lawyer. Colangelo-Bryan is a young lawyer who, in his own words, is “cynical by nature” and takes all his clients’ reports with “a grain of salt.”<sup>13</sup> When he took on the representation of several Bahraini detainees at Guantánamo in 2004, he took their concerns with an even “bigger grain of salt” than he would in a typical case of commercial litigation.<sup>14</sup> One of those detainees, Jumah Al-Dossari, had been in Camp 5, the maximum-security facility, for extended periods. The blocks in Camp 5 have solid walls, with the only access to the outside world being a food-tray slot on a door that opens to a hall

‘restraint chairs’ to force-feed them and isolate them from one another after finding that some were deliberately vomiting or siphoning out the liquid they had been fed.” *Id.* In addition, Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, on *The Kojo Nnamdi Show*, *supra* note 8, referred to the chair as “the restraint mechanism.” This was confirmed in private conversations with a senior DOD official who reports to Dr. William Winkenwerder. I also heard about the chair in a lengthy conversation on March 24, 2006, with Kristine Huskey, attorney for several Kuwaiti detainees in Guantánamo.

11. This was reported to me by Joshua Colangelo-Bryan, defense attorney for detainees, and by Dr. Stephen Xenakis, retired Army Brigadier General in the Medical Corps. Both spoke at a conference on “Voices from Guantánamo,” held at George Washington University Law School on March 20, 2006.

12. I heard this in private conversations with Joshua Colangelo-Bryan and Kristine Huskey, defense attorneys for several detainees. In notes from one detainee’s lawyer, a client said he was force-fed a 1200cc bag that consisted of “Two Cal, 1 can of Jevity, and water,” as well as another bag with the same mix, plus “Mag Citrate” (magnesium citrate). Mag Citrate is commonly used as a laxative for evacuating the colon before a colonoscopy. *See also The Kojo Nnamdi Show*, *supra* note 8.

13. Colangelo-Bryan described himself and his work on detainee cases in a conference held at George Washington University Law School on March 20, 2006.

14. *Id.*

where large industrial fans drown out any attempt at conversation. Not surprisingly, Al-Dossari suffered from the psychological stress of isolation. During their consultations, Al-Dossari said that, in interrogation sessions, he was wrapped in an Israeli flag, chained to a floor while a female interrogator put on his face what he believed to be menstrual blood, and beaten unconscious by guards. The attorney was initially skeptical of some of the statements until he later read FBI memos and a book by a military officer that detailed the same interrogation techniques his client had described, including the menstrual blood tactic.

In the spring of 2005, while Al-Dossari was still in Camp 5, he asked his attorney in a quiet voice, “What can I do from going crazy?”<sup>15</sup> On October 15, 2005, Colangelo-Bryan went to Guantánamo to consult with him. During the interview, Al-Dossari said he needed to go to the bathroom. Colangelo-Bryan called in the military police so that they could remove the shackles holding Al-Dossari to the floor in the meeting area. The attorney then walked out of the room and the MPs took Al-Dossari to a small cell with a toilet, located on the other side of the meeting area and separated from it by a steel mesh wall. A couple of minutes went by, and then a few more. The attorney had a sense that something might be wrong and peeked into the door to the meeting area. There he saw a pool of blood. He looked up to find a gaunt figure hanging from the mesh wall on the cell side, his face covered in blood, his body limp, his eyes rolled back in his head, and his lips and mouth swollen and protruded. He called in the MPs who cut down Al-Dossari from the mesh wall and, at the attorney’s request, began performing CPR. Colangelo-Bryan was ordered to leave, but, as he left, he heard Al-Dossari gasp for air.

Al-Dossari survived this suicide attempt, but during his time at Guantánamo he has tried to commit suicide eleven other times.<sup>16</sup> There were three successful suicides at Guantánamo by other detainees in June of 2006.<sup>17</sup> After Al-Dossari’s October 15 suicide attempt, his attorney asked for his transfer to a less isolating camp, some meaningful social interaction, a few books, and one telephone call with his family. All four requests were denied. Al-Dossari then filed a motion with the court that was also denied.<sup>18</sup> The court argued that he was not isolated because he had been interrogated twenty-nine times over the past two years—“a novel

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15. *Id.*

16. Colangelo-Bryan told me this in a conversation in Fall 2006.

17. See Josh White, *Three Detainees Commit Suicide at Guantánamo*, WASH. POST, June 11, 2006, at A1.

18. Colangelo-Bryan told me this in a conversation in Fall 2006.

legal position,”<sup>19</sup> his attorney commented (though perhaps in line with the notion that rapport building is, as I was told by Hood, the preferred method of interrogation at Guantánamo). Because the Graham-Levin Amendment to the Detainee Treatment Act of 2005<sup>20</sup> stripped the courts’ habeas corpus jurisdiction over detainee cases and was recently reaffirmed in the Military Commissions Act,<sup>21</sup> Al-Dossari’s team has not been able to obtain legal relief.

Legal issues aside, Al-Dossari’s case raises concerns about the role of psychiatrists and behavioral therapists at Guantánamo. In particular, were mental health workers involved in decisions about Al-Dossari’s isolation and restrictions? Are they typically involved in such decisions?

I present these vignettes in order to pinpoint morally troubling medical issues that remain part of our detention policy at Guantánamo. In what follows, I want to isolate several psychological mechanisms that enable doctors and health care workers, both sixty years ago and now, to insulate their moral consciences.

We hear much about Guantánamo as a legal black hole—one that falls between the cracks of the laws of armed conflict and the federal criminal law system.<sup>22</sup> But Guantánamo is also a moral black hole. It is a place where, by design, morality is made to recede. Unfortunately, the methods by which morality disappears at Guantánamo are not novel.

In the Nazi period, euphemistic and scientific language played a critical role in the medicalization of killing. Thus, killing “life unworthy of life” (and the term came to denote Jews, homosexuals, Roma, Catholic critics, the mentally ill, the physically feeble, or other “impure” strains) was a matter of “euthanasia.”<sup>23</sup> The Greek word, to the ears of some Nazi

19. See *supra* note 13.

20. See Federal Judiciary Emergency Special Sessions Act of 2005, Pub. L. No. 109-163, 119 Stat. 3136 (2005); Center for Constitutional Rights: Statement on Dangers of Courtstripping and Graham-Levin Amendment, <http://www.ccr-ny.org> (search “Graham-Levin Amendment”) (last visited Apr. 8, 2007).

21. Military Commissions Act of 2006, Pub. L. No. 109-366, 120 Stat. 2600 (2006).

22. For David Luban’s insightful analysis of the war on terror as a hybrid of the laws of war and laws of crime, see David Luban, *The War on Terrorism and the End of Human Rights*, in *WAR AFTER SEPTEMBER 11* (Verna V. Gehring ed., Rowman and Littlefield 2003). I am indebted to a forum held at Georgetown Law School on Sept. 25, 2006 exploring the Congressional debate on the Military Commissions Act, *supra* note 21. See also *A Legal Black Hole*, <http://dir.salon.com/story/news/feature/2004/01/17/military/index.html> (last visited Apr. 8, 2007); USA: Guantánamo detainees—the legal black hole deepens, <http://web.amnesty.org/library/Index/ENGAMR510382003> (last visited Apr. 8, 2007); John Steyn, *Guantánamo Bay: The Legal Black Hole*, 53 INT’L & COMP. L.Q. 1 (2004).

23. See ROBERT JAY LIFTON, *NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF KILLING* 45–79 (Basic Books 2000) (1983).

doctors, retained the positive overtones of its etymological root. Adolf Wahlmann, medical director at the killing institution Hadamar, was eager to insist on legal testimony.<sup>24</sup> Wahlman defended lethal injection as “a completely painless method,”<sup>25</sup> and noted that “the term euthanasia comes from the Greek eu, which means beautiful.”<sup>26</sup> Imagery of “therapeutic killing,” “killing as healing and cure,” “killing for the sake of the strong and the healthy,” helped to further promote the myth of “special treatment” as therapeutic.<sup>27</sup> Medical questionnaires, evaluations, and statistical analysis under professorial leadership and management—in short, the stuff of institutionalized science and academe—all added to the legitimization of the process.<sup>28</sup>

Institutions such as Guantánamo are not killing centers like Hadamar—that is not the comparison I want to make. But, they have been torture centers, and euphemisms and medicalized terms have helped insulate practitioners from moral conflict. As one enters the Guantánamo detention center, one passes under a gateway that reads “Honor Bound.” Despite the growing desperation of the inmates about their treatment, the sign is still in place. Behavioral science consultants (BSCs), who are members of Behavioral Science Consultation Teams (BSCTs, pronounced “biscuits”), are typically military psychologists who help tailor individual interrogation plans. The acronyms insert psychological distance between mental health and interrogation, as does the fact that a “biscuit” is never physically present in an interrogation room with a detainee, but on the other side of a two-way mirror.

Coerced consent of victims was an explicit feature of the Nazi period. In the T4 prototype for the final solution, the policy was to gain “consent” from the parents of mentally ill children for the transfer of their children to the “Children’s Specialty Departments,” also euphemistically known as “Therapeutic Convalescent Institutions.”<sup>29</sup> Those who showed reluctance were threatened with removal of guardianship.<sup>30</sup>

The coercion implicit in force-feeding at Guantánamo is very different; it is more nuanced in its attitude toward the moral subject; and, it is aimed at keeping people alive. Still, it ought to worry us. A hunger striker,

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24. *Id.* at 101.

25. *Id.* at 101.

26. *Id.* at 101.

27. *Id.* at 14–16.

28. *Id.* at 65–70.

29. *Id.* at 53.

30. *Id.* at 55.

according to officials with whom I spoke at Guantánamo, is a detainee who misses nine meals.<sup>31</sup> Consent to being force-fed is expressed, according to the base doctors,<sup>32</sup> by the absence of active resistance.<sup>33</sup> Arguably, in certain circumstances, force-feeding is the humane response of a doctor to a hunger striker. There may be circumstances where a patient lacks adequate autonomy to make an informed choice. But, this would suggest that a doctor or staff member's prior obligation ought to be to promote, to the degree possible, circumstances that enable autonomous choice, such as consultation with trusted persons, whether family members or clergy. It is not clear whether these steps have been taken at Guantánamo.

In Tim Golden's article,<sup>34</sup> Edmonson, who was the senior medical doctor at the base, reflected candidly, "Any time you're doing a procedure that the patient doesn't want, it's not a place you want to be . . . What takes precedence? The patient's rights or their life? It's not an easy question."<sup>35</sup> Yet, saving life at Guantánamo has often seemed more of a politically motivated concern than a humanitarian one.

Lifton's study makes clear how a highly bureaucratic division of labor and roles diffuses a sense of individual responsibility for one's actions.<sup>36</sup>

31. This is how hunger strike was defined to me by General Jay Hood, who was the commanding officer in charge of the detention center in October 2005. See World Medical Association, The World Medical Association Declaration of Tokyo, Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, May 20, 2006, available at <http://www.wma.net/e/policy/c18.htm> (last visited Apr. 8, 2007) (declaring that "Where a prisoner refused nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such voluntary refusal of nourishment, he or she shall not be fed artificially"). Note that, as of June 2006, a new Department of Defense medical directive states that "involuntary treatment" must be preceded by "counseling concerning the risks of refusing consent." DOD Instruction 2310.08E, *Medical Program Support for Detainee Operations* § 4.72 (June 6, 2006), available at <http://www.dtic.mil/whs/directives/corres/pdf/231008p.pdf>. It is not clear just how this is implemented, however.

32. The chief medical officer at the base at the time was Capt. John Edmonson. During my trip, I was told that one doctor had been punched in the mouth by a striker during force-feeding; that was among the reasons we were given for not being allowed to observe strikers.

33. This was communicated during our briefing at the detention center.

34. See *supra* note 4.

35. See also DOD Instruction 2310.08E, *supra* note 31, § 4.71.

In the case of a hunger strike, attempted suicide, or other attempted serious self-harm, medical treatment or intervention may be directed without the consent of the detainee to prevent death or serious harm. Such action must be based on a medical determination that immediate treatment or intervention is necessary to prevent death or serious harm, and, in addition, must be approved by the commanding officer of the detention facility or other designated senior officer responsible for detainee operations.

This means a non-doctor could override a doctor's recommendations.

36. LIFTON, *supra* note 23, at 495–97.



This point is by now a well-documented part of the working of Nazi machinery.<sup>37</sup> Psychological and moral numbing is, in part, a result of seeing oneself as not really “in charge” of decisions. On this view, actions are perceived as beyond one’s own doing, making, or stopping.

Guantánamo, too, divides labor in a way that aims at professional insulation. During my visit, one of the pressing questions posed to the visiting team was not whether psychologists or psychiatrists should consult on interrogation plans, but rather, which professional should. The preference among some Pentagon advisers was to use psychologists rather than psychiatrists for intelligence gathering.<sup>38</sup> One reason seemed to be that psychologists, as non-physicians, are not perceived as strictly bound by the Hippocratic maxim, requiring they do no harm, as are physicians. Also, psychologists have a strong tradition of working in forensics, where the client is not the patient. Not irrelevant, perhaps, is that the American Psychological Association has been less explicit, until very recently, in its condemnations of participation at Guantánamo than the American Psychiatric Association.<sup>39</sup>

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37. See, DAVID LUBAN, *LEGAL MODERNISM* 335–78 (University of Michigan Press 1994) (appealing to Arendt and Marx in his discussion of bureaucracy and the fragmentation of action into “action shards”).

38. I learned this through nonattribitional remarks made at a dinner at Andrews Air Force Base immediately following my Guantánamo trip. See DOD Instruction 2310.08E, *supra* note 31:

Health care personnel engaged in a professional provider-patient treatment relationship with detainees shall not participate in detainee-related activities for purposes other than health care. Such health care personnel shall not actively solicit information from detainees for other than health care purposes. Health care personnel engaged in non-treatment activities, such as forensic psychology, behavior science consultation, forensic pathology, or similar disciplines, shall not engage in any professional provider-patient treatment relationship with detainees (except in emergency circumstances in which no other health care providers can respond adequately to save life or prevent further impairment).

39. After considerable urging from many of its members, the American Psychological Association announced at its annual meetings, in the summer of 2007, that it will bar its members from association with several methods used in interrogation techniques (including waterboarding (i.e., simulated drowning), hooding, forced nakedness, use of dogs to frighten detainees, exposure to extreme heat and cold, sexual and religious humiliation, exploitation of phobias) and possibly strip those professionals associated with such techniques from APA membership. (See The Washington Post, Monday August 20, 2007, A3: “APA Rules on Interrogation Abuse,” by Shankar Vedantam.) The American Psychological Association’s previous report, issued in July 2005, stated only that psychologists consulting in interrogation involving national security should be “mindful of factors unique to these roles and contexts that require ethical consideration.” American Psychological Association, *Report of the American Psychological Association Presidential Task Force* (June 2005), available at <http://www.apa.org/releases/PENSTaskForceReportFinal.pdf>. The American Psychiatric Association has been more restrictive from the outset in its guidelines. In 2005 it stated that members can serve as behavior consultants so long as there is no “coercive” element to the interrogation. See Neil Lewis, *Guantánamo Tour Focuses on Medical Ethics*, N.Y. TIMES, Nov. 13, 2005, at A19.

The very discussion about which kind of health care provider ought to support interrogation should raise red flags. If the “ought” is a moral one, then no health professional of any stripe ought to be involved in interrogation where there is strong institutional pressure to use coercive techniques and torture. Moreover, the institutional separation of psychiatrists from interrogation does not itself excuse them from complicity while serving in non-interrogational roles. This is because it is unlikely that clinicians at Guantánamo remain ignorant of the actual conditions of interrogation and confinement. Indeed, in Al-Dossari’s case, as his psychological conditions worsened, he requested help from mental health clinicians vis-à-vis release from the extreme isolation of Camp 5 and access to more meaningful social contact.<sup>40</sup> According to his attorney, their reply was that they could do nothing, and that he had to speak to his interrogator.<sup>41</sup> So, in this case at least, clinicians seemed aware of a detainee’s reports of suicidal depression, yet subordinated treatment to security. Thus, even if the institutional role of treatment is on paper separate from the interrogation role, those who treat can still cede their professional responsibility to those who interrogate.

I have drawn on lessons from the past not in order to shock or hyperbolize, but to alert us to an aspect of our current detention largely occluded by focus on legal issues. It remains unclear how, if at all, the recently passed Military Commissions Act<sup>42</sup> will affect medical and interrogation practices at Guantánamo. Also unclear is the toll our policies will take on the interrogators and health care providers themselves. But, what remains clear is that more than three hundred individuals are still serving indefinite sentences at Guantánamo. The majority of those already released have been returned to their home countries. The voices of the detainees need to be heard.

I conclude with the voice of Jumah Al-Dossari from a note passed to his attorney in a sealed envelope, as they began their meeting on October 15, 2005. At the time of their meeting, Al-Dossari told Colangelo-Bryan not to bother with the note; they would talk about it later. About four months later, the government declassified the suicide note:

I know it is an awful and horrible scene, but there is no other alternative to make our voice heard by the world from the depths of the detention centers, except this way, in order for the world to

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40. *See supra* note 13.

41. *Id.*

42. *See supra* note 21.

reexamine its standing and for the fair people of America to look again at the situation and try to have a moment of truth with themselves . . . . When you remember me . . . remember that the world let us down and let our case down. Remember that our governments let us down. Remember the unreasonable delay of the courts in looking to our case and deciding the victims of justice . . . . I thank you for everything you have done for me. But I have one last request. Show the world my letters. Let the world read them. Let the world know of the agony of the detainees in Cuba.<sup>43</sup>

Al-Dossari's voice is eloquent. And some, including one medical official to whom I spoke,<sup>44</sup> may be eager to discount it as a clever appeal for sympathy by a well-educated terrorist. But, in remembrance of Nuremberg and the international moral law it set in place, this is no time to let cynicism or fear best our humanity.

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43. *Id.*

44. I spoke to this official in Fall 2006, on a nonattribitional basis. The official reports to Dr. William Winkenwerder.