

On Defining Torture

DISCUSSED: FCC censorship, doin' the Lynndie, John Yoo's long shadow, controversial medical opinions, the Hippocratic Oath, pancuronium bromide, Eighth Amendment law, American Medical Association ethics policy on physician participation in lethal injection, the Guillotine, renovations at Abu Ghraib (that's the Baghdad Central Prison to you), Iraqi landscaping, Mohammad al-Qahtani's paranoia, the Universal Declaration of Human Rights, the future of American democratic ideals

It's a sad fact that any new revelations about American torture policy during the "War on Terror" fail to excite either indignation or horror. From the point of view of the Bush Administration, it might have been fortunate that the first widely disseminated documentary evidence of Americans torturing so-called enemy combatants were the gruesome Abu Ghraib snapshots. Though many of the images were judged too gruesome to be displayed on American television in the current environment of FCC-driven censorship, the scenes of hooded, stacked, and beaten brown bodies lying in front of smiling Midwesterners evoked a modicum of disgust from the public. Since this spectacular initial view of the reality of American counter-terrorism policy, print journalists reporting on the latest disturbing facts have faced the challenging task of topping these shocking photographs if their stories are to gain traction. This task has proven to be nearly impossible and thus the public discussion of American torture has become increasingly abstract, even as more specific details have emerged. Each investigation that reveals evidence of CIA rendition flights or classified legal opinions loosening rules on detainee treatment has been both a major victory against a government with a strong presumption for secrecy and a defeat in the ongoing struggle to keep the public's attention. The public shame born of Bush administration torture policy has rushed along efforts to move past this "history" even though we are just beginning to learn the true extent of the problems.

Recently, the Washington Post reported the first on-the-record statement from a high-ranking Administration official acknowledging CIA torture in the US prison at Guantánamo Bay. Susan Crawford, who was named convening authority of military commissions by Defense Secretary Robert Gates in February 2007, told the Post's Bob Woodward that "We tortured [Mohammed al-] Qahtani. His treatment met the legal definition of torture. And that's why I did not refer the case" for prosecution.¹ Though Crawford's statement is the most senior admission of both the existence and the implications of American policy disregarding the Geneva Conventions, national, and military law, it barely caught public notice, since it only verified what the country already knows and doesn't want to hear.

While this statement comes from a prosecutor whose case has been indelibly tainted by officially sanctioned misconduct, its details reveal the contorted logic of the government's human rights policy in the age of American torture. Woodward explains how Crawford ultimately decided to define this detainee abuse as torture:

Crawford, 61, said the combination of the interrogation techniques, their duration and the impact on Qahtani's health led to her conclusion. "The techniques they used were all

¹ Bob Woodward, "Detainee Tortured, Says U.S. Official." *Washington Post*, January 14, 2009.
<http://www.washingtonpost.com/wp-dyn/content/article/2009/01/13/AR2009011303372.html>

authorized, but the manner in which they applied them was overly aggressive and too persistent. . . . You think of torture, you think of some horrendous physical act done to an individual. This was not any one particular act; this was just a combination of things that had a medical impact on him, that hurt his health. It was abusive and uncalled for. And coercive. Clearly coercive. It was that medical impact that pushed me over the edge” to call it torture, she said.

Here, the language of medicine has been put at the service of a legal system, which follows rules made up along the way, in order to classify this particular case as an official instance of torture. Though many would argue that allowing the discipline of medicine to scientifically define the limits of torture is the only logical way to approach the legal question of whether an interrogator’s particular act constitutes an impermissible instance of torture, there are (un)intended consequences of this criterion.

The stakes of this definition are high. In order for the Obama Administration to follow through on its pledge to close Guantánamo Bay and undo illegal Bush-era detention policies, detainees currently classified in the legally dubious category of “enemy combatants” must be brought back within the framework of the American judicial system. It is currently unclear whether the White House will direct pending terrorism and conspiracy cases to civilian criminal courts or military courts-martial but either way it will be necessary to come to terms with the treatment of detainees in the past. The most difficult cases will certainly be the ones in which torture has undeniably occurred. It is hard to imagine how prosecutors will be able to bring charges against these defendants, who have been subjected to brutality at the hands of American personnel. In these situations, the national security apparatus will be hard pressed to keep allegedly dangerous detainees in prison indefinitely in the face of petitions for writs of *habeas corpus* while fulfilling Obama’s campaign promises to restore and protect civil liberties. Thus, the ongoing categorization of past abuses as either torture or not carries substantial political and legal weight and will be a delicate task for whoever is responsible.

While it was not inevitable that medicine would have been tapped to explain torture today – centuries after civilized judicial systems forsook torture as a legitimate method of punishment – it is certain that the existing legal system cannot handle this new challenge alone. Insofar as official sanction of coercive interrogation methods is still restricted to a shadow legal system of secret memos and classified Justice Department opinions (masterminded by the team of David Addington, John Yoo, and I. Lewis “Scooter” Libby under the direction of Dick Cheney) mainstream legal discourse has no prescribed method for determining the current legal limits of torture. Indeed, the task of uncovering the extent of this shadow legal framework for Bush’s “War on Terror” is an ongoing and important process; the true degree to which this convoluted network of legal documents and signing statements has changed American law and national security practice is still unknown.

Now, the legal system is forced to turn to other domains in order to rebalance the operating definitions of its own categories. Medicine satisfies these needs on several levels. First, medical discourse is accorded a unique degree of impartiality that makes it a suitable basis for defining American notions of justice. The image of a doctor, guided by the morality of his Hippocratic Oath, unambiguously saving the life of a guilty man or an enemy soldier bestows medical opinion with respect for being both fair and unbiased. Second, the scientificity of medicine provides an apparently empirical basis for its judgments. Doctors are able to deploy the latest theories and tests to determine how a particular action affects the life-sustaining functions of the body or even provide a measurement for the amount of pain it causes. The results of these analyses can be finely parsed and exact limits can be declared. In this way, medicine is also objective, since it can theoretically be applied in the same way in every case. Finally, medicine

has the requisite authority to serve as a foundation for contentious legal categories. Few other discourses are entrusted with as much responsibility or paid as much respect as medicine. Indeed, doctors already occupy privileged positions within the judicial system.

Since the prohibition of torture is a fundamental tenant of American law, permanently enshrined in the eighth amendment to the U.S. Constitution, it is difficult to trace a domestic history of this particular medico-legal relationship. However, it might help to examine the role of medicine in the evolving debate over capital punishment, a contentious issue in which medicine has been a crucial player. The long history of American debate over executions has featured a continuing effort to minimize their barbarity and stimulated the development of a wide range of techniques from the gallows to the electric chair to the firing squad. At several points during the past two centuries, the Supreme Court has heard challenges to the constitutionality of particular execution methods, most recently in 2008. In *Baze v. Rees*, the Court faced the question of whether Kentucky's use of the lethal three-drug cocktail, currently employed in thirty-six states, constituted cruel and unusual punishment. In a highly disputed, ninety-two page decision the Court ruled 7-2 in support of the protocol. There were two major issues at play in the case that might have value in trying to understand how the legal deployment of medical knowledge might work with respect to torture.

First is the issue of the medical supervision necessary for a constitutionally permissible lethal injection. The question before the court hinged on whether the three-drug cocktail could be administered properly, preventing the condemned from experiencing the undeniably painful death caused by the second and third drugs in the cocktail, pancuronium bromide and potassium chloride. The first drug, sodium thiopental, is intended to prevent an unusually cruel death by anaesthetizing the inmate at the beginning of the procedure. This relatively complex task requires a medically trained attendant to properly place an intravenous catheter and inject a sufficient amount of sodium thiopental to cause the inmate to go completely unconscious.

In her dissent, Justice Ruth Bader Ginsberg compares Kentucky's execution procedure with those of other states. She notes that while Kentucky requires the two members of the IV team to be medically trained (one member is a phlebotomist, the other an EMT), these people leave the execution chamber after inserting the catheters; only the warden and the deputy warden remain in the chamber while the lethal drugs automatically flow one after the other into the inmate's arm. Justice Ginsberg argued that since neither of the wardens have medical training nor do they make any attempt to determine whether the anesthetic successfully rendered the inmate unconscious, the risk of a painful death was too substantial. In contrast, other states, such as Missouri, require medical personnel to determine whether the first drug worked before continuing with the procedure. These safeguards ensure the inmate a "peaceful death."

The problems surrounding this medical intervention are not difficult to imagine and have already caused problems with lethal injection proceedings. The Hippocratic Oath, which guides the ethical practice of medicine, forbids doctors from actions that intentionally harm a patient. In response to this unique challenge, Article 2.06 of the American Medical Association's Code of Medical Ethics states, "A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution."² When a doctor violates this code by assisting in some aspect of a lethal injection procedure he risks losing his license, squandering his credibility, and harming his relationships with patients.

² American Medical Association. *Health and Ethics Policies of the AMA House of Delegates*, November 2008. <http://www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf> p. 533

The situation is similar with regard to torture and interrogations; sections 2.067 and 2.068 of the AMA ethics code unequivocally prohibit physicians from participating in either practice. The rules not only prevent doctors from providing material assistance to interrogators but also prohibit supplying or withholding their professional knowledge in the service of intelligence agents. Physicians may not even “monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.”³ These standards clearly oppose the kind of physician involvement that would be necessary were torture’s legal definition to be defined by medical standards of harm. Even *ex post facto* medical evaluations of previous interrogations would be problematic, since doctors’ participation would enable intelligence personnel to get by with harmful actions that don’t meet the bar for classification as torture. This is analogous to the existing ban on doctors pronouncing inmates dead on the execution table. Consequently, medical participation at any stage in the interrogation process would force doctors to either violate their professional codes of conduct or require groups such as the AMA to unreasonably weaken their ethical expectations.

In the case of executions, government sometimes uses its legal power to help doctors skirt the ethical requirements of their craft. Many of the seventeen states requiring medical supervision of lethal injection have protections in place to shield physicians’ identities and grant them blanket immunity from attempts to strip them of their licenses.⁴ These deceptive measures would be unworkable in the context of torture. Under this regime, a doctor’s testimony about whether a particular act constituted torture would be one of the most contentious points of a prosecution. Concealing a doctor’s identity would undermine his very status as an expert witness. Thus, the discipline of medicine risks doing itself irreparable harm if it allows doctors to be complicit in carrying out or evaluating government torture.

The second important issue in *Baze v. Rees* is Kentucky’s use of the second drug, pancuronium bromide, which paralyzes the inmate, causes asphyxiation, and prevents muscle spasms while he dies. The legal danger is that this paralysis can prevent an insufficiently anesthetized inmate from reacting to the excruciating pain of potassium chloride coursing through the bloodstream, subjecting him to an unusually cruel death. In his highly critical concurrence, Justice John Paul Stevens pointed out that there is absolutely “no therapeutic purpose” in using pancuronium bromide. (This is a strange way of putting it, what is the *therapeutic purpose* of the other drugs? How can the therapeutic purpose even be defined if the therapy is execution?) While Chief Justice John Roberts’ plurality opinion argues, “the commonwealth has an interest in preserving the dignity of the procedure,” Justice Stevens contends that “Whatever minimal interest there may be in ensuring that a condemned inmate dies a dignified death, and that witnesses to the execution are not made uncomfortable... is vastly outweighed by the risk that the inmate is actually experiencing excruciating pain that no one can detect.”⁵ In many ways, this debate sounds like a modern, scientific version of the eighteenth-century French arguments over use of the Guillotine, a machine intended to reduce the brutality of public executions.

Indeed, this debate has been a recurring one; as new methods of sovereign violence are invented, the old styles of killing are immediately revealed to be inhumane and antiquated. In his seminal historiography of Western judicial punishment, Michel Foucault connects this ongoing effort to humanize executions to the continual “disappearance of punishment as a spectacle”

³ *Ibid.* p. 534

⁴ Atul Gwande, *Better: A Surgeon’s Notes on Performance*, (New York: Metropolitan, 2007), p. 135.

⁵ John Paul Stevens. *Concurrence, Baze v. Rees*. (Washington: Supreme Court of the United States, 2008), p. 41. <http://www.scotusblog.com/wp/wp-content/uploads/2008/04/07-5439.pdf>

since the eighteenth century.⁶ In place of the now horrifying, all-day festivities surrounding medieval torture, modern penal systems conceal the shame of actual punishment inside prisons, restricting public view of the violence bound up in its practices. This process, pushed along by prison reform groups and changing standards of public morality, has severed the connection between punishment and the body of the condemned by eliminating pain as the constituent element of the legal penalty. Instead of punishing the inmate with horrific torture in the town square, modern penal systems aim to affect the soul of their convicts with the bidirectional pressures of loss of wealth or rights and forced programs of self-improvement. As a matter of fact, the latest news from the Baghdad Central Prison, the shiny new name for the notorious Abu Ghraib, is about the renovation of the prison complex Saddam Hussein built. In an effort to modernize the institution, the Iraqi government had the prison repainted and outfitted the cellblocks with flat screen televisions and new facilities including a barber shop, a sewing workshop, a library, a computer lab, and a playground for inmates to use with their children on visiting day. Flowers and decorative lampposts now line the prison's driveway.⁷ But do these improvements really humanize the notorious prison complex? It is hard to know, since the group of reporters visiting the prison did not see a single one of the 400 inmates, who were all locked away in a cellblock that was not part of the tour.

Even the most "enlightened" penal systems continue to exert some force on inmates' bodies, even while they shun torture. These vestiges of corporeal violence – "rationing of food, sexual deprivation, corporal punishment, solitary confinement" – are the "trace[s] of 'torture' in the modern mechanisms of criminal justice."⁸ It is the relative visibility of these traces of violence that determines a modern penal system's progressivity or humanity. This explains the compelling state interest in using pancuronium bromide to maintain the dignity of executions. Here, medical knowledge is deployed onto the bodies of the condemned in order to make their expirations appear as peaceful as possible. The (albeit limited) biological science supporting the use of pancuronium bromide does not function medicinally but rather socially; it supports the material practice of justice by concealing what would otherwise be capital punishment's visible disruptions of the peaceful penal narrative. It might even be said that medicine helps people overcome the moral prohibitions that might otherwise position them in opposition to capital punishment.

It is their violation of this imperative to conceal violence that makes the photographs of detainee abuse at Abu Ghraib so transgressive. The images of Lyndie England and her comrades humiliating and physically assaulting their charges make the shame of penal violence visible to a public unaccustomed to seeing uncontrolled "criminal justice" in practice. Foucault evokes the paradoxically shameful relationship between justice and punishment: "It is ugly to be punishable, but there is no glory in punishing.... Those who carry out the penalty tend to become an autonomous sector; justice is relieved of responsibility for it by a bureaucratic concealment of the penalty itself."⁹ By making visible the most shameful of violences, the Abu Ghraib snapshots violate the impulse, shared equally by the American government and public, to conceal the gruesome penal realities of the "War on Terror."

The weight of responsibility for this shame is the source of the collective effort to lay the blame for prisoner abuse on a few rotten apples and undertrained National Guardsmen. (The same logic applies to the cases of Guantánamo Bay torture, which are continually blamed on

⁶ Michel Foucault, *Discipline and Punish*, Trans. Alan Sheridan (New York: Vintage, 1995), p. 8.

⁷ Sam Dagher, "Fresh Paint and Flowers at the Iraqi House of Horrors." *New York Times*, February 21, 2009, <http://www.nytimes.com/2009/02/22/world/middleeast/22iraq.html>

⁸ Foucault, *Discipline and Punish*. p. 16.

⁹ *Ibid.* p. 10.

overzealous CIA agents and civilian intelligence contractors, not the high-ranking Justice Department officials who constructed the legal justifications for abuse and defended the need for “enhanced interrogation” in front of Congressional committees.) If the problem is a low-level one, can it not be explained as a failure in an otherwise functional system? Certainly, when high-ranking Pentagon and Bush Administration officials are implicated in the production of these conditions, when newly unearthed documents reveal carefully constructed, secret legal opinions justifying these atrocities the shame is shared, it is our collective shame. While the adage “war is hell” might be able to contain and excuse the horrors of the “War on Terror,” decisions made in the quiet corridors of Washington D.C. represent the *truth* of our judicial system. Indeed, the existence of Yoo and Addington’s shadow legal system resuscitates old questions about the role of intelligence operations in a democracy. How can officials be held accountable for decisions judged to be too sensitive for public disclosure? Do Americans collectively bear responsibility for atrocities conducted without their knowledge but perpetrated by the people they have chosen to lead?

The Abu Ghraib images’ sheer brutality recalls the horrors of colonialism – as told by Conrad – and it is precisely this imperial motivation that our politics continuously disavow. The pure pointlessness of the abuse and the gleeful expressions on the soldiers’ faces are relics of a political reality at odds with America’s stated mission to bring democracy and human rights to the repressive Middle East. The insidious rhetoric championing democratic values and signaling a pseudo-personal relationship between peoples (remember how the Iraqis were supposed to have welcomed American soldiers with flowers and open arms?) only made the shame worse, for government malfeasance translates into violence done in our names.

Deploying medical knowledge onto this situation reasserts some level of authority, organization, control, and professionalism that counteract the frightening sense of the “War on Terror” as an abusive free-for-all. But, the very characteristics of stability and respect that make medicine an attractive basis for defining legal categories extend to conceal the acts themselves. Just as pancuronium bromide conceals the corporeal violence of execution, cloaking torture in the discourse of medicine bestows human rights abuses with a veneer of respectability. For people seduced by the allure of information extracted by waterboarding an “al Qaeda operative,” knowledge of medical supervision might be sufficient to excuse this otherwise objectionable practice. One can already imagine Limbaugh’s quip: “Liberals should stop complaining, these terrorists’ interrogations are conducted under the supervision of a doctor. That’s more than many Americans without health insurance can say about their own lives.”

This very attraction to enhanced interrogations as a way to gather information about terrorist threats demonstrates how a medical definition of torture misses the mark. Detainee abuse is intended neither to extract a confession (since it would be surely inadmissible in court) nor to punish “terrorists” for past deeds (since it is conducted in secret). Though they are physically harmful, interrogators’ use of stress positions, solitary confinement, and humiliation is intended to cause a psychological breakdown in order to extract information about alleged terrorist activities. This identified need for information is the source of the supposedly compelling state interest “justifying” the use of rough interrogation tactics. Indeed, Gitanjali S. Gutierrez, Mohammad al-Qahtani’s civilian attorney, told Woodward about the debilitating psychological effects of his client’s time at Guantánamo. “There is no doubt [Qahtani] was tortured,” he said. “He has loss of concentration and memory loss, and he suffers from paranoia.”¹⁰ These problems are certainly the result of more than interrogation sessions alone; human rights advocates have documented the use of induced hypothermia, nonstop

¹⁰ Bob Woodward, “Detainee Tortured, Says U.S. Official.” *Washington Post*.

bombardment with loud rock music, and prolonged sleep deprivation in American detention centers.¹¹ The psychological symptoms of long-term mistreatment are inaccessible to a rigorous medical examination, which is restricted to observing the physical condition of a patient. Thus, a stringent medical definition of torture might still allow interrogators to get away with using morally repugnant techniques to extract information from detainees.

Finally, law's appropriation of medical discourse distorts America's moral and legal understanding of abuse. Consider the prohibitions on torture in the Universal Declaration of Human Rights:

Article 5 – No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment.

Article 6 – Everyone has the right to recognition everywhere as a person before the law.¹²

These standards do not speak of torture in relation to some medically defined threshold of harm. Instead, they appeal to the ideals of human dignity and personhood that must undergird any robust democratic morality. By fracturing the public (and legal) perception of American interrogation policy with the alleged neutrality of medical categorization, this rationalizing approach to determining the limits of torture ensures that any sense of humanity is lost among definitions and biometric data. Of course, there is the danger that a future set of clever government attorneys be able to craft a new set of legal opinions justifying harsh interrogation tactics that do not cause long-term medical harm but violate international law and accepted moral standards. But the use of medicine to define the legal boundaries of torture could have effects far more insidious and difficult to detect. Might the involvement of medicine provide cover for an ongoing campaign of undemocratic counter-terrorism policies? Might these technocratic legal standards themselves instigate radical revisions to our collective morality that will weaken our objections to torture? It is difficult to predict.

Nevertheless, it is crucial to remember that even the election of Barack Obama and his swiftly issued executive order directing the government to close the detention facility at Guantánamo Bay do not mark an end to America's shameful detainee abuse. A human rights lawyer representing thirty-one Guantánamo detainees recently reported "a ramping up in abuse since President Obama was inaugurated" from guards "basically trying to get their kicks in right now for fear that they won't be able to later."¹³ These legal battles over the definition of torture should not be confused with an analysis of history; allegations of torture will continue until the "War on Terror's" shadow legal system is abandoned and the Obama administration brings these "enemy combatants" back into domain of established law. The definition of torture is not an academic debate over semantics. It is a real fight over the moral foundations of our legal system and has real implications for the welfare of current and future detainees, the profession of medicine, and the health of our democracy.

¹¹ Amnesty International, "Iraq: Torture not Isolated." Amnesty International Press Release, April 30, 2004. <http://www.amnesty.org/en/library/asset/MDE14/017/2004/en/dom-MDE140172004en.html>

¹² General Assembly of the United Nations, *The Universal Declaration of Human Rights*, 1948. <http://www.un.org/Overview/rights.html>

¹³ Luke Baker, "Exclusive: Lawyer says Guantánamo abuse worse since Obama." *Reuters*, February 25, 2009. <http://www.reuters.com/article/newsOne/idUSTRE51O3TB20090225>