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Keeping Doctors out of the Interrogation Room: A New Ethical Obligation that Requires the Backing of the Law

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NOTE

KEEPING DOCTORS OUT OF THE
INTERROGATION ROOM:
A NEW ETHICAL OBLIGATION
THAT REQUIRES THE BACKING
OF THE LAW[†]

Ayham Bahnassi^{††}

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INTRODUCTION

The World Medical Association ("WMA") has provided in its Declaration of Geneva that members of the medical profession must never use their "medical knowledge to violate human rights and civil liberties, even under threat."¹ Moreover, a fundamental tenet of the Hippocratic Oath requires physicians to "do no harm."² However, despite these ethical obligations, military physicians stationed at Guantanamo Bay, Cuba have collaborated with interrogators in carrying out coercive interrogation methods against detainees.³ The New England Journal of Medicine has reported that physicians at U.S. detention facilities have shared detainees' medical files with interrogators; have helped interrogators in designing interrogation strategies

¹ WORLD MED. ASS'N, DECLARATION OF GENEVA (2006), *available at* <http://www.wma.net/e/policy/c8.htm>.

² Alan Johnson, *Debate Grows on Humaneness of Lethal Injection: Supreme Court Ruling Intensifies Discussion*, COLUMBUS DISPATCH, June 22, 2006, at D3. *See also* Christopher J. Levy, Comment, *Conflict of Duty: Capital Punishment Regulations and AMA Medical Ethics*, 26 J. LEGAL MED. 261, 268 (2005).

³ Neil A. Lewis, *Interrogators Cite Doctors' Aid at Guantanamo*, N.Y. TIMES, June 24, 2005, at A1.

that were customized to a detainee's medical condition; and have trained interrogators on how to question detainees.⁴ Military physicians have also advised interrogators on ways to exploit detainees' fears and increase their stress levels.⁵ There have even been reports suggesting that physicians have participated in the waterboarding of detainees.⁶

In response to these troubling allegations of medical complicity in the abusive treatment of detainees under US custody, the WMA amended its Declaration of Tokyo in 2006 by stating that a "physician shall 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."⁷ Both the American Medical Association ("AMA") and the American Psychiatric Association ("APA") have also revised their ethical guidelines in response to allegations that physicians have cooperated with interrogators in the mistreatment of detainees.⁸ The AMA recently issued Opinion 2.068, which bars physicians from participating in interrogations.⁹ Similarly, the APA promulgated a Position Statement that unambiguously prohibits psychiatrists from participating in interrogations.¹⁰

⁴ M. Gregg Bloche & Jonathan H. Marks, *When Doctors Go to War*, 352 NEW ENG. J. MED. 3, 3 (2005).

⁵ Lewis, *supra* note 3.

⁶ Mark Ridley-Thomas, *Evil in Our Midst: Why We Must Pass California Senate Joint Resolution 19 on Torture*, CAL. PROGRESS REP., Apr. 9, 2008, http://www.californiaprogessreport.com/2008/04/evil_in_our_mid.html. See also N.Y. State Assembly, News from Assemblymember Richard N. Gottfried, Anti-Torture Bill Moves in Albany (Feb. 9, 2008), <http://assembly.state.ny.us/mem/?ad=075&sh=story&story=27896> (noting that U.S. Attorney General Robert Mukasey argued "waterboarding was not torture because it was monitored and limited by someone with medical training."); See also Dan Eggen, *White House Pushes Waterboarding Rationale; Administration May Be Trying to Shore Up Prosecution of Terrorism Suspects*, WASH. POST, Feb. 13, 2008, at A3.

⁷ WORLD MED. ASS'N, 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 (2006), available at <http://www.wma.net/e/policy/c18.htm>.

⁸ The American Psychological Association has also voted to enact new ethical guidelines that will prohibit psychologists from participating in interrogations. See Benedict Carey, *Psychologists Vote to End Interrogation Consultations*, N.Y. TIMES, Sept. 18, 2008, at A26. However, this Note shall primarily focus on the medical profession and its response to the issue of physician participation in interrogations.

⁹ COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 2.068(2), at 30 (2008) [hereinafter CODE OF MEDICAL ETHICS].

¹⁰ Am. Psychiatric Ass'n, *Psychiatric Participation in Interrogation of*

However, medical ethics alone will not deter all physicians from using their medical skills to facilitate coercive and psychological interrogations, because ethical codes promulgated by private medical societies do not operate with the same force of law as statutes promulgated by state legislatures.¹¹ Moreover, since the United States Department of Defense ("DoD") has shown a complete disregard for the new ethical guidelines promulgated by the AMA and APA, state governments should proactively assume the responsibility in preventing their licensed physicians from participating in the interrogation of detainees.

The primary purpose of this note is to discuss and analyze the various ways to legislate against the practice of physician participation in interrogations. State lawmakers have at least three legislative measures to choose from to prevent their licensed physicians from participating in interrogations. One option is to enact a statute that explicitly provides that licensed physicians are prohibited from participating in interrogations. Currently, New York is the only state that is considering this legislative measure.¹² The justification for this legislative approach stems from the disheartening outcomes in the existing case law regarding the medical license challenges of physicians that have participated in the executions of inmates by lethal injection. Even though the AMA has prohibited physicians from participating in lethal injection executions of prisoners since 1980,¹³ most states either permit or require physicians to participate in lethal injection executions.¹⁴ Consequently, no physician has ever been disciplined for taking part in lethal injection executions simply because state courts have held that the practice of physician participation in execution is not illegal.¹⁵ Thus, to ensure the successful enforcement of Opinion 2.068, state lawmakers should enact a statute

Detainees: Position Statement (May 2006), <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200601.aspx>.

¹¹ See 1994 Va. Op. Att'y Gen. 85 (1994).

¹² Assem. B. 9891, 231st Legis. Sess. (N.Y. 2008).

¹³ See CODE OF MEDICAL ETHICS, *supra* note 9, 2.06, at 20.

¹⁴ Levy, *supra* note 2, at 264.

¹⁵ See Order Granting Plaintiff's Request for Declaratory Relief & Denying Defendant's Motion to Dismiss at 5, N.C. Dep't. of Corr. v. N.C. Med. Bd., No. 07-CVS-3574 (N.C. Super. Ct. Div. Sept. 21, 2007), <http://www.newsobserver.com/content/media/2007/9/21/DOC092107.pdf> [hereinafter Court Order] (granting the North Carolina Department of Corrections's injunction against the North Carolina Medical Board from "taking disciplinary action against physicians who have participated in or otherwise have been involved in judicial executions by lethal injection. . . ."); see also, *Zitrin v. Ga. Composite State Bd. of Med. Examiners*, 653 S.E.2d 758, 763 (Ga. Ct. App. 2007).

that unequivocally bars physicians from participating in interrogations.

State lawmakers, however, may hesitate to enact a statute that explicitly forbids physicians from engaging in interrogation activities due to a fear that their constituents will view them as interfering with the federal government's mission to win the war on terror. Thus, a second option would be to enact a statute that authorizes a state medical board to discipline licensed physicians for violating any provision of the AMA's Code of Ethics. Such a legislative measure would implicitly prohibit licensed physicians from engaging in interrogation activities, since the AMA has expressly barred physicians from doing so.¹⁶ Currently, three states have expressly authorized their medical boards to discipline their licensees for violating any provision of the AMA Code of Ethics: Ohio,¹⁷ Kentucky,¹⁸ and Hawaii.¹⁹ However, this note shall primarily focus on Ohio's medical licensing statute, O.R.C. §4731.22(B)(18), since Ohio courts have rendered more opinions regarding the state medical board's use and interpretation of the AMA Code of Ethics than either the courts of Kentucky or Hawaii. An examination of Ohio's case law concerning O.R.C. §4731.22(B)(18) reveals that if the Ohio Medical Board ever decided to discipline a licensee for violating Opinion 2.068, it would have the legal authority to do so. Thus, Ohio's experience with its medical licensing statute may make it a good model for other states to follow.

The third legislative measure that state legislators can carry out to deter their licensed physicians from taking part in interrogating detainees is to enact a resolution, as opposed to a statute, that publicly condemns the practice of physician participation in interrogations. Thus far, California is the only state that has implemented this legislative measure by enacting Senate Joint Resolution No. 19, which urges the federal government to remove all Californian licensed health professionals from any interrogation activities at US detention facilities.²⁰ In addition, SJR 19 requests that all relevant California agencies inform their health professional licensees that those who participate in coercive or "enhanced" interrogation may be subject to prosecution.²¹ While SJR 19 may signal a strong message by the state legislature that physician participation in interrogations is morally repugnant, it unfortunately is not as effective as the two statutory measures men-

¹⁶ CODE OF MEDICAL ETHICS, *supra* note 9, 2.068(2), at 30.

¹⁷ OHIO REV. CODE ANN. § 4731.22(B)(18) (LexisNexis 2000).

¹⁸ KY. REV. STAT. ANN. § 311.597(4) (West 2006).

¹⁹ HAW. REV. STAT. § 453-8(a)(9) (2007).

²⁰ S.J. Res. 19, 2007-2008 Reg. Sess. (Cal. 2008).

²¹ *Id.*

tioned above, because the California Supreme Court has held that a mere resolution does not have the same force of law as a statute.²² Thus, state legislatures should only enact a resolution in lieu of a statute if the political environment within the state would not permit them to enact a statute that either explicitly or implicitly prohibits physicians from participating in interrogations.

This note asserts that the first legislative option, enacting a statute that expressly prohibits physicians from participating in interrogations, is the best way to prevent the involvement of physicians in interrogations. Part I discusses the role that physicians have played in interrogating detainees held in Guantanamo Bay, Cuba and other U.S. military sites. Part II shall discuss the new ethical guidelines promulgated by the AMA and APA regarding the practice of physician participation in interrogations. This section shall also show that both international and domestic codes of medical ethics unanimously declare that physician participation in interrogations violates principles of medical ethics. Part III will examine the various legislative measures that state lawmakers can enact to bar their licensed physicians from engaging in interrogations. Part III-A explains why the disciplinary proceedings against physicians who took part in executions by lethal injection failed. State courts have refused to discipline physicians for partaking in executions because the courts had no statute to invoke that explicitly prohibited physician participation in executions. To prevent a similar outcome in cases involving physician participation in interrogations, lawmakers should enact a statute that expressly prohibits such conduct. Part III B focuses on Ohio's medical licensing statute, which permits the Ohio State Medical Board to discipline physicians for conduct that violates the AMA's Code of Ethics. If enacting a statute that explicitly prohibits a physician to participate in interrogations is not possible, then Ohio's medical licensing statute serves as a suitable alternative. Part III C analyzes the effectiveness of a resolution enacted by a state legislature, as opposed to a statute, that effectively condemns the practice of physician participation in interrogation. While a resolution that forbids licensed physicians from participating in interrogation is not the best legislative option in addressing the matter, it is certainly better than inaction.

²² *Mullan v. State*, 114 Cal. 578, 584 (1896) ("A mere resolution . . . is not a competent method of expressing the legislative will, where that expression is to have the force of law, and bind others than the members of the house or houses adopting it.").

I. BACKGROUND ON PHYSICIAN PARTICIPATION IN INTERROGATIONS

On May 7, 2004, the Wall Street Journal publicized a confidential and previously undisclosed report by the International Committee of the Red Cross ("ICRC").²³ There, the ICRC concluded that some of the interrogation methods used against the detainees held in Abu Ghraib were "tantamount to torture."²⁴ The ICRC drew the exact same conclusions after inspecting the U.S. detention facility in Guantanamo Bay in June 2004.²⁵ The ICRC officials had full access to inspect U.S. detention facilities in Abu Ghraib and Guantanamo under an arrangement that the ICRC has made with governments for decades.²⁶ In exchange for unrestricted access to the detention facility and an opportunity to meet with detainees, the ICRC promised the Bush administration to keep its findings confidential.²⁷

In its confidential reports regarding Guantanamo Bay, the ICRC inspection team concluded that medical doctors participated in designing several physical and psychological interrogation techniques.²⁸ One of the most frequently used interrogation techniques is hooding.²⁹ Hooding refers to the interrogation method in which the interrogator places a sandbag over a detainee's head while the detainee's hands are handcuffed. Hooding disorients the detainees by preventing them from seeing and breathing freely.³⁰ According to the ICRC, interrogators frequently used hooding in conjunction with beatings, thereby increasing the detainee's anxiety as to when the next blow would

²³ David S. Cloud, Carla Anne Robbins & Greg Jaffe, *Red Cross Found Widespread Abuse of Iraqi Prisoners: Confidential Report Says Agency Briefed U.S. Officials On Concerns Repeatedly*, WALL ST. J., May 7, 2004, at A1. Founded in 1863, the ICRC is a Geneva based and neutral organization that provides humanitarian protection for victims of war. Neil A. Lewis, *Red Cross Finds Detainee Abuse in Guantanamo*, N.Y. TIMES, Nov. 30, 2004, at A1.

²⁴ REPORT OF THE INTERNATIONAL COMMITTEE OF THE RED CROSS (ICRC) ON THE TREATMENT BY THE COALITION FORCES OF PRISONERS OF WAR AND OTHER PROTECTED PERSONS BY THE GENEVA CONVENTIONS IN IRAQ DURING ARREST, INTERNMENT AND INTERROGATION ¶ 59 (2004), http://www.globalsecurity.org/military/library/report/2004/icrc_report_iraq_feb2004.htm [hereinafter ICRC REPORT].

²⁵ Lewis, *supra* note 23 (reporting that interrogation methods in Guantanamo were "tantamount to torture").

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.* at A1.

²⁹ ICRC REPORT, *supra* note 24, at ¶ 25.

³⁰ *Id.*

come.³¹ Interrogation methods have also included acts of sexual humiliation and provocation.³² For example, in Abu Ghraib, interrogators forced detainees to remain naked for several days.³³ According to the ICRC, some detainees were being paraded naked outside their cells in front of either other detainees or guards, including female guards, while hooded or wearing women's underwear over their head.³⁴ Additionally, interrogation methods included prolonged periods of solitary confinement,³⁵ sleep deprivation,³⁶ painful bodily positions,³⁷ exposure to loud music and strobe lights,³⁸ exposure to extreme temperatures,³⁹ and the use of military dogs to induce fear and injury.⁴⁰ Declassified Pentagon documents eventually confirmed that physicians played a significant role in facilitating these abusive interrogation techniques.

In 2004, the Pentagon appointed Vice Admiral Albert T. Church III to investigate allegations of detainee abuse in U.S. detention facilities.⁴¹ In the spring of 2005, Vice Admiral Church released a three hundred sixty eight page report regarding the mistreatment of detainees held in U.S. detention facilities ("Church Report").⁴² Unfortunately, most of the report remains classified.⁴³ However, in the unclassified section, the Church Report concludes that some physicians played a profound role in interrogating detainees held in U.S. detention facilities. According to the Church Report, some physicians "observe[d] interrogations, assess[ed] detainee behavior and motivations, review[ed] interrogation techniques, and offer[ed] advice to interrogators."⁴⁴ The sworn statement of Colonel Thomas M. Pappas,

³¹ *Id.*

³² M. Gregg Bloche & Jonathan H. Marks, *Doctors and Interrogators at Guantanamo Bay*, 353 NEW ENG. J. MED. 6, 6 (2005).

³³ ICRC REPORT, *supra* note 24, at ¶ 27.

³⁴ *Id.*

³⁵ PHYSICIANS FOR HUMAN RIGHTS, BREAK THEM DOWN: SYSTEMATIC USE OF PSYCHOLOGICAL TORTURE BY US FORCES 3 (2005), available at <http://www.physiciansforhumanrights.org/library/documents/reports/break-them-down-the.pdf>.

³⁶ Bloche & Marks, *supra* note 32, at 6.

³⁷ *Id.*

³⁸ Susan Okie, *Glimpses of Guantanamo - Medical Ethics and the War on Terror*, 353 NEW ENG. J. MED. 2529, 2532 (2005).

³⁹ *Id.*

⁴⁰ PHYSICIANS FOR HUMAN RIGHTS, *supra* note 35, at 7.

⁴¹ Jane Mayer, *The Experiment*, THE NEW YORKER, July 11 & 18, 2005, at 60, 61.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ OFFICE OF THE ASSISTANT SEC'Y OF DEF., U.S. DEP'T OF DEF., EXECUTIVE SUMMARY 19 (2005), available at <http://www.defenselink.mil/news/Mar2005/>

chief of military intelligence in Iraq, also revealed the significant role that physicians have played in the interrogations of detainees held in U.S. detention facilities.

In his February 2004 testimony regarding allegations of detainee abuse at Abu Ghraib, Colonel Pappas explained that physicians and psychiatrists were “on hand to monitor” the interrogations.⁴⁵ Colonel Pappas testified that interrogators provided a doctor and a psychiatrist with “a copy of the interrogation plan and a written note as to how to execute [them].”⁴⁶ According to Colonel Pappas’s testimony, the doctor and psychiatrist not only examined the interrogation plans, but also had a “final say as to what is implemented.”⁴⁷ Thus, Colonel Pappas’s testimony and the findings of the Church Report revealed that physicians stationed in U.S. detention facilities were aware of the occurrences of these abusive interrogation methods, and that they signed off on several interrogation plans that involved the deliberate infliction of physical and mental pain.

In February 2008, new reports also surfaced suggesting that the DoD used physicians to monitor the waterboarding of detainees.⁴⁸ Waterboarding involves strapping a detainee to an inclined board with his head lower than his feet and placing a cloth over his face.⁴⁹ The interrogator then proceeds to pour water over the detainee’s mouth and nose to simulate the feelings of drowning.⁵⁰ The State Department has condemned the use of waterboarding as an interrogation technique, and the U.S. Field Manual explicitly prohibits its use.⁵¹ However, when the lawyers at the Justice Department’s Office of Legal Counsel evaluated the legality of the technique, they concluded in a pair of memoranda that waterboarding was not torture “because its use was monitored and limited by someone with medical training

d20050310exe.pdf [hereinafter EXECUTIVE SUMMARY] (providing a summary of the results of the Department of Defense’s review of detention operations and interrogation techniques).

⁴⁵ Colonel Thomas M. Pappas’s Sworn Statement and Interview 6 (Feb. 9, 2004), <http://www.usnews.com/usnews/news/articles/040709/Pappas.pdf>.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ Eggen, *supra* note 6, at A3, (reports that Justice Department’s Office of Legal Counsel at one time concluded that waterboarding does not constitute torture because its use was monitored by medical expert whose role was to limit the infliction of pain). See also N.Y. State Assembly, *supra* note 6 (“In February 2008, the Washington Post reported on U.S. Attorney General Robert Mukasey’s argument that waterboarding was not torture because it was monitored and limited by someone with medical training.”).

⁴⁹ Eggen, *supra* note 6, at A3.

⁵⁰ *Id.*

⁵¹ *Id.*

whose role was to limit the severity of the pain.”⁵² This admission contained in these memoranda, one of which still remains undisclosed to the public,⁵³ suggests that physicians may have assisted interrogators in subjecting detainees to waterboarding in order to provide legal cover for the technique.

Generally, physician participation in interrogation can be classified in four distinct categories. First, physicians have played a pivotal role in the interrogations of detainees by handing over detainees’ medical records to the interrogators, who could then use the confidential health information to exploit the detainees’ physical and psychological weaknesses.⁵⁴ Second, the U.S. Army used physicians from the U.S. Air Force to medically clear detainees for harsh interrogations.⁵⁵ Third, some physicians played an even more direct role in the interrogations by serving as members of the Pentagon’s Behavioral Science Consultant Teams (“BSCT”). BSCT personnel devised interrogation strategies and provided oversight over the interrogations.⁵⁶ Lastly, physicians stationed in U.S. detention facilities neglected to report to higher authorities wounds that were clearly caused by abusive interrogation methods.⁵⁷ In failing to report the mistreatment of detainees, military physicians allowed many abusive interrogation techniques to continue for long periods of time.

A. Interrogators’ Access to Detainees’ Medical Files

On June 10, 2004, the Washington Post reported that interrogators had access to detainees’ medical files that were generated by the medical personnel at Guantanamo Bay or other detention facilities around the world.⁵⁸ Brig. Gen. Rick Backus, who commanded the Guantanamo Bay facility from March 2002 to October 2002, told the Washington Post that “after new detainees were processed and given a medical review, their records were routinely shared with military intelligence personnel. Military doctors and medics were available to

⁵² *Id.*

⁵³ *Id.*

⁵⁴ Peter Slevin & Joe Stephens, *Detainees’ Medical Files Shared: Guantanamo Interrogators’ Access Criticized*, WASH. POST, June 10, 2004, at A1; Robert Jay Lifton, *Doctors and Torture*, 351 N.E.W. ENG. J. MED. 415, 415 (2004); Bloche & Marks, *supra* note 4, at 3.

⁵⁵ STEVEN H. MILES, OATH BETRAYED: TORTURE, MEDICAL COMPLICITY, AND THE WAR ON TERROR 55 (2006).

⁵⁶ *Id.* at 53-56.

⁵⁷ Lifton, *supra* note 54, at 415.

⁵⁸ Slevin & Stephens, *supra* note 54, at A13.

advise interrogators about the new detainees' health."⁵⁹ On November 30, 2004, the New York Times similarly reported that interrogators sometimes went directly to members of the medical staff at Guantanamo Bay to learn about a detainee's medical condition.⁶⁰ Official orders given to military medical personnel later confirmed these media reports.⁶¹

A U.S. Southern Command ("SoCom") policy statement, which has been in effect since August 6, 2002, informs medical care providers at U.S. detention facilities that communications between detainees and military medical personnel "are not confidential and are not subject to the assertion of privileges' by detainees."⁶² Indeed, SoCom's policy statement requires military physicians to provide clinical information to interrogation teams on request.⁶³ The policy statement also instructs military physicians to volunteer any information that they believe might be of value to the interrogators.⁶⁴ Thus, the Pentagon implicitly authorizes interrogators to have unrestricted access to a detainee's private medical records. The Church Report expressed concerns over this practice.⁶⁵

The Church Report explains that allowing interrogators to have "unfettered" access to detainees' health records was problematic for two reasons. First, if interrogators had direct access to a detainee's medical file, then the interrogator could use that information to improperly exploit the detainee during interrogations.⁶⁶ Second, such access would discourage detainees from truthfully revealing their health information to the medical personnel at the U.S. detention facilities.⁶⁷ Detainees refused to candidly discuss their psychiatric problems with the medical personnel in U.S. detention facilities because they feared that interrogators would use that information against them during interrogations.⁶⁸ Clearly, if this practice of physicians sharing detainees' medical records with interrogators continues, then the quality of the medical care in U.S. detention facilities will deteriorate.⁶⁹

⁵⁹ *Id.*

⁶⁰ Lewis, *supra* note 23.

⁶¹ Bloche & Marks, *supra* note 32, at 6-7.

⁶² *Id.* at 6.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ EXECUTIVE SUMMARY, *supra* note 44, at 20.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ PHYSICIANS FOR HUMAN RIGHTS, *supra* note 35, at 47.

⁶⁹ *Id.*

B. Using Physicians to Medically Clear Detainees for Harsh Interrogations

Military physicians were also used to medically clear detainees for harsh interrogation.⁷⁰ For example, in late 2004, the U.S. Army brought in an Air Force medical team to Iraq to examine Abu Ghraib detainees before and after interrogation.⁷¹ The purpose of using the Air Force medical team rather than the Army's medical team was to eliminate any appearance of a conflict of interest that would have existed if the Army medically cleared detainees for interrogation, questioned them, and then examined them for injuries afterwards.⁷² While this Army-Air Force arrangement may satisfy conflict of interest concerns, it does not resolve the alarming concern that medical exams were provided for non-therapeutic purposes.⁷³ The goal of the U.S. Air Force medical exams was not to maintain the health of the detainee, but rather to vet the detainees for interrogation procedures that included solitary confinement, sleep deprivation, stress positions, dietary manipulation, and so on.⁷⁴

The medical findings from the U.S. Air Force pre-interrogation exams were eventually transferred to a group called Behavioral Science Consultation Teams ("BSCT").⁷⁵ General Geoffrey Miller, who became commander of Guantanamo in late 2002, created BSCT (pronounced "biscuit")⁷⁶ in order to integrate the information from the pre-interrogation medical exams with the design of future interrogation plans.⁷⁷

C. Doctors Serving as Behavioral Science Consultants to Interrogators

BSCT consists of psychologists and psychiatrists who serve as behavior consultants to the interrogators.⁷⁸ Unlike the other medical personnel at U.S. detention facilities, BSCT medical personnel provide no patient care services to the detainees. BSCT psychologists

⁷⁰ MILES, *supra* note 55, at 55.

⁷¹ *Id.* at 54-55.

⁷² *See id.* at 55.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.* at 53.

⁷⁶ *Id.*; Lewis, *supra* note 23.

⁷⁷ MILES, *supra* note 55, at 53.

⁷⁸ *Id.*

and psychiatrists are known as “non treating” professionals because they use their skills for intelligence gathering purposes only.⁷⁹

While they are not the actual interrogators, BSCT psychologists and psychiatrists are nonetheless directly and thoroughly part of the interrogation process. BSCT health personnel are responsible for developing interrogation strategies for each detainee.⁸⁰ Additionally, BSCT personnel perform psychological assessments of detainees, suggest physically and psychologically coercive interrogation plans for detainees, and teach behavioral techniques to interrogators.⁸¹ BSCT health personnel also prepare psychological profiles for the interrogators’ use, observe interrogations behind one-way mirrors, and provide feedback to the interrogators.⁸² BSCT personnel have also helped interrogators to exploit detainees’ psychological and physical weaknesses.⁸³ For example, a detainee’s fear of the dark or being alone would be exploited by various interrogation techniques in order to gain intelligence.⁸⁴ Thus, the primary function of a BSCT scientist is to point out the detainee’s vulnerabilities to the interrogators so that the latter may exploit them during the interrogations.⁸⁵

In essence, BSCT health consultants used their medical and psychological expertise to help interrogators break down a prisoner’s resistance to answering questions.⁸⁶ Towards this end, BSCT psychologists and psychiatrists are required to receive specialized training in “Survival, Evasion, Resistance, and Escape” (SERE),⁸⁷ The U.S. military created the SERE program at the end of the Korean War in order to train its soldiers to resist torture.⁸⁸ The theory behind SERE was that by exposing U.S. soldiers to abusive treatment, they would be better prepared to cope with torture should they ever face it in the real world.⁸⁹ However, BSCT scientists have reverse engineered the SERE program and rather than using it for defensive purposes, BSCT scientists are using the data from the SERE program to inflict pain on the detainees.⁹⁰ BSCT scientists have learned from the

⁷⁹ Mayer, *supra* note 41, at 63.

⁸⁰ MILES, *supra* note 55, at 53-54.

⁸¹ *Id.* at 54.

⁸² Bloche & Marks, *supra* note 32, at 7.

⁸³ MILES, *supra* note 55, at 54-55.

⁸⁴ *Id.* at 55.

⁸⁵ Leonard S. Rubenstein, *First, Do No Harm: Health Professionals and Guantanamo*, 37 SETON HALL L. REV. 733, 740 (2007).

⁸⁶ MILES, *supra* note 55, at 55.

⁸⁷ Mayer, *supra* note 41, at 63.

⁸⁸ *Id.*

⁸⁹ *Id.* at 64.

⁹⁰ *Id.*

SERE program that “[o]ne way to stimulate acute anxiety . . . is to create an environment of radical uncertainty.”⁹¹ Therefore, detainees “are hooded; their sleep patterns are disrupted; they are starved for extended periods; they are stripped of their clothes; they are exposed to extreme temperatures; and they are subjected to harsh interrogations.”⁹² Psychological research suggests that by forcing a detainee to experience tremendous anxiety, his capacity for “self-regulation” – the ability to control his behavior – is greatly weakened.⁹³ Thus, if a detainee is trying to withhold secrets from an interrogator, he is much less likely to succeed if he has been “deprived of sleep or is struggling to ignore intense pain.”⁹⁴

The SERE program has also studied psychological interrogation techniques that involve sexual humiliation and embarrassment. Erik Saar, a former Army intelligence analyst at Guantanamo and the author of “Inside the Wire,” told *The New Yorker Magazine* that “the notion of using sexual gambits to unnerve detainees was promoted by ‘the BSCTs, who were these psychiatrists and psychologists from Fort Bragg.’”⁹⁵ Thus, military psychiatrists may have participated in devising some of the most heinous and debasing forms of interrogation.

D. Physicians Failing to Report Detainees’ Abuses and Injuries

Physicians have also facilitated the abusive interrogations conducted by failing to report injuries that were clearly caused by torture.⁹⁶ For example, the *New York Times* reported that two physicians at Abu Ghraib “recognized that a detainee’s shoulder was hurt because he had his arms handcuffed over his head for what they said was ‘a long period.’”⁹⁷ The two physicians provided the detainee with painkillers to treat his dislocated shoulder and then sent him to an outside hospital.⁹⁸ However, they did not report any suspicions of abuse to the higher chains of command.⁹⁹ Had they done so, perhaps the abuses at Abu Ghraib would have ended much sooner. The abusive interrogation methods at Abu Ghraib did not become public

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.* at 65.

⁹⁶ Lifton, *supra* note 54, at 415.

⁹⁷ Kate Zernike, *The Reach of War: The Witnesses; Only a Few Spoke Up on Abuse As Many Soldiers Stayed Silent*, N.Y. TIMES, May 22, 2004, at A1.

⁹⁸ *Id.*

⁹⁹ *Id.*

until Specialist Joseph Darby, a 24-year-old from Maryland, left a disc with evidence of abuse and an anonymous letter describing its content to his superiors.¹⁰⁰ According to the New York Times, mistreatment at Abu Ghraib “was not only widely known but also apparently tolerated, so much so that a picture of naked detainees forced into a human pyramid was used as a screen saver on a computer in the interrogation room.”¹⁰¹ Since physicians are ethically committed to their “patients first and foremost”¹⁰² and are required to report and document abuse or suspicions of abuse,¹⁰³ military physicians at Abu Ghraib should have been the first to alert higher authorities at the Pentagon of the abuses at Abu Ghraib, not Specialist Darby.

The interrogation logs of Mohammad al-Qahtani, who many suspected of being the “20th hijacker” on September 11th, also reveals the failure of military physicians to either stop the abusive interrogations or to report the abuses. According to the interrogation logs, military physicians frequently monitored Qahtani’s physical condition, “sometimes as often as three times a day. . . .”¹⁰⁴ The reasons for constant medical monitoring of Qahtani are not precisely known, but it could mean either profound concern about Qahtani’s health or an effort by military physicians to calibrate the amount of stress that Qahtani’s body could endure.¹⁰⁵ Furthermore, Major John Leso, a BSCT psychologist, monitored the interrogation of Qahtani.¹⁰⁶ Thus, because of their deep involvement, military health personnel were complicit in the abusive treatment of Qahtani.

The interrogation logs show that medics intravenously administered 3 ½ bags of fluids while Qahtani was tied to a chair. When Qahtani asked to use the bathroom, the guards told him he had to answer questions first. After answering the questions, he requested his promised bathroom break.¹⁰⁷ Unsatisfied with his answers, the

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, at xvi (2006) [hereinafter CODE OF MEDICAL ETHICS, *Preamble*].

¹⁰³ See Lifton, *supra* note 54, at 416 (“American doctors at Abu Ghraib and elsewhere have undoubtedly been aware of their medical responsibility to document injuries and raise questions about their possible source in abuse;”). See also MILES, *supra* note 55, at 122 (stating “[p]hysicians are responsible for collecting medical evidence from injured patients who report being assaulted”).

¹⁰⁴ Adam Zagorin & Michael Duffy, *Inside the Interrogation of Detainee 063*, TIME, June 20, 2005, at 26, 27.

¹⁰⁵ *Id.*

¹⁰⁶ Bloche & Marks, *supra* note 32, at 7.

¹⁰⁷ Zagorin & Duffy, *supra* note 104, at 30.

interrogator told Qahtani to urinate in his pants, which he humiliatingly did.¹⁰⁸ In addition, dogs were frequently used in interrogating Qahtani. The interrogation logs reveal that Qahtani's interrogator "told him that he needed to learn, like a dog, to show respect."¹⁰⁹ Subsequently, the interrogator forced Qahtani to perform dog tricks on a leash¹¹⁰ in order to raise his status from a detainee to that of a dog.¹¹¹ Qahtani's interrogators also subjected him to interrogation techniques that involved sexual humiliation. For example, interrogators forced Qahtani to stand naked in front of female interrogators and to wear women's underwear.¹¹² Qahtani was also exposed to incessantly loud music, and the BSCT psychologist insisted that interrogators deprive Qahtani of sleep.¹¹³

Qahtani became very ill as a result of the harsh interrogation methods.¹¹⁴ His interrogators brought in a doctor, and the abusive interrogation was temporarily paused for an unprecedented 24 hours.¹¹⁵ However, while under medical care, Qahtani was still subjected to loud music preventing him from sleeping.¹¹⁶ A military physician reported that Qahtani's heart rate dropped to 35 beats a minute.¹¹⁷ His slow heart rate was caused by hypothermia, which was "intentionally induced by means of air conditioning."¹¹⁸ Such heart disturbances are very life-threatening.¹¹⁹ One doctor administered an electrocardiogram, while another performed a CT scan.¹²⁰ Military officials also flew in a radiologist from the Roosevelt Roads Naval Air Station in Puerto Rico, 600 miles away from Guantanamo, to read the CT scans.¹²¹ Alarming, the physicians who treated Qahtani for his ailments eventually returned him to his interrogators.¹²²

According to Stephen Xenakis, a psychiatrist and former brigadier general in the Army medical corps, the doctors involved in treating Qahtani should have notified the higher chains of command about

¹⁰⁸ *Id.*

¹⁰⁹ Anthony Lewis, *Guantanamo's Long Shadow*, N.Y. TIMES, June 21, 2005, at A21.

¹¹⁰ Rubenstein, *supra* note 85, at 734.

¹¹¹ Lewis, *supra* note 109.

¹¹² Rubenstein, *supra* note 85, at 734-35.

¹¹³ See Mayer, *supra* note 41, at 68.

¹¹⁴ *Id.*

¹¹⁵ Zagorin & Duffy, *supra* note 104, at 32.

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ MILES, *supra* note 55, at 61.

¹¹⁹ *Id.*

¹²⁰ Zagorin & Duffy, *supra* note 104, at 32.

¹²¹ *Id.*

¹²² MILES, *supra* note 55, at 61.

how ill the interrogations were making Qahtani, “as is required by virtually every code of medical ethics.”¹²³ However, an FBI agent, not the physicians that treated Qahtani, eventually complained about the abusive treatment that Qahtani had to endure.¹²⁴ In a letter to the Pentagon, the FBI agent wrote that Qahtani “had been ‘subjected to intense isolation for over three months’ and ‘was evidencing behavior consistent with extreme psychological trauma (talking to non existent people, reporting hearing voices, crouching in a cell covered with a sheet for hours on end).’”¹²⁵ If these symptoms were evident to an FBI agent, then the physicians that treated Qahtani should have also detected his diminishing mental health as a result of the harsh interrogations. As advocates for their patients, the physicians that treated Qahtani for his slow heart rate and hypothermia should have been the first to complain about his mistreatment, not the FBI agent.

Mental health experts have concluded that many of these interrogation techniques such as sleep deprivation, induced hypothermia, and waterboarding can have a profoundly harmful effect on a detainee’s mental and physical health.¹²⁶ Detainees are already under a great deal of stress and anxiety because they have been held indefinitely, have not been properly charged, have not had access to an attorney, and do not know the reason for their confinement.¹²⁷ Each day of being held indefinitely without due process worsens the profound psychological impact on the detainees.¹²⁸ Additionally, Guantanamo has an exorbitantly high suicide rate among its detainees. From the time the facility opened until June of 2006, there have been “41 suicide attempts by 25 detainees.”¹²⁹ These attempts may have resulted from the abusive interrogation methods¹³⁰ and the “deep despair felt by the inmates who are being held indefinitely.”¹³¹ Furthermore, medical and psychological research reveals that harsh psychological techniques such as “severe humiliation, inducement of fear, hooding, and other techniques can bring about severe anxiety,

¹²³ Mayer, *supra* note 41, at 68-69.

¹²⁴ MILES, *supra* note 55, at 61.

¹²⁵ Zagorin & Duffy, *supra* note 104, at 33.

¹²⁶ Rubenstein, *supra* note 85, at 743.

¹²⁷ Neil A. Lewis, *Red Cross Criticizes Indefinite Detention in Guantanamo Bay*, N.Y. TIMES, Oct. 10, 2003, at A5.

¹²⁸ Jonathan H. Marks, *Doctors as Pawns? Law and Medical Ethics at Guantanamo*, 37 SETON HALL L. REV. 711, 712 (2007).

¹²⁹ James Risen & Tim Golden, *Three Prisoners Commit Suicide at Guantanamo*, N.Y. TIMES, June 11, 2006, at A1.

¹³⁰ Jerome A. Singh, *Military Tribunals at Guantanamo Bay: Dual Loyalty Conflicts*, 362 THE LANCET 573, 573 (2003).

¹³¹ Risen & Golden, *supra* note 129.

post traumatic stress disorder, cognitive impairment, depression, and even psychotic symptoms.”¹³² These symptoms were apparent to several observers at Guantanamo, such as FBI agents and ICRC officials.¹³³ Military physicians in U.S. detention facilities should have been the first to detect and report these symptoms. If military physicians had fulfilled their ethical reporting obligations, then perhaps the human rights concerns in U.S. detention facilities would have been addressed much sooner.

II. ETHICAL GUIDELINES REGARDING PHYSICIAN PARTICIPATION IN INTERROGATIONS

Since the media’s coverage of the mistreatment of detainees held in Guantanamo and Abu Ghraib in 2004, the Bush Administration has not sufficiently changed the medical practices at U.S. detention facilities. On June 6, 2006, the Pentagon promulgated a new set of instructions for military health care personnel entitled “Medical Program Support for Detainee Operations” (“2006 DoD Instructions”).¹³⁴ The 2006 DoD Instructions still authorize BSCT physicians to “supervise, conduct or direct interrogations.”¹³⁵ However, in June 2006, the AMA added Opinion 2.068 into its Code of Ethics, which bars the practice of physician participation in interrogations.¹³⁶ The APA also promulgated new ethical codes in 2006 that explicitly bar psychiatrists from participating in interrogations.¹³⁷

A. Current Medical Practice at U.S. Detention Facilities

The Bush Administration contends that when BSCT physicians participate in interrogations, they are not violating their ethical obligations.¹³⁸ Dr. David Torenberg, Deputy Assistant Secretary of Defense for Health Affairs, espouses the view that physicians who are exclusively assigned to military intelligence production do not have a doctor-patient relationship with detainees.¹³⁹ Dr. Torenberg asserts that when physicians participate in interrogations, they are not acting

¹³² Rubenstein, *supra* note 85, at 736.

¹³³ *Id.*

¹³⁴ DEP’T OF DEF., INSTRUCTION: NUMBER 2310.08E 1 (2006), http://www.fas.org/irp/doddir/dod/i2310_08.pdf.

¹³⁵ *Id.* at 5.

¹³⁶ See CODE OF MEDICAL ETHICS, *supra* note 9, 2.068, at 30.

¹³⁷ Am. Psychiatric Ass’n, Psychiatric Participation in Interrogation of Detainees: Position Statement (May 2006), <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200601.aspx>.

¹³⁸ Bloche & Marks, *supra* note 4, at 4.

¹³⁹ *Id.*

as physicians, but as combatants, which makes the Hippocratic Oath and its obligations to patient welfare inapplicable.¹⁴⁰ The Bush Administration believed that so long as the military separates the military medical personnel into two distinct groups – one devoted to clinical care and the other devoted to intelligence production – then the practice of physician participation in interrogations is legitimate.¹⁴¹ The 2006 DoD Instructions reflect this view.

The 2006 DoD Instructions divide the responsibilities of the military medical personnel into two. One group of military physicians is in charge of the medical care of detainees, while the other group is in charge of military intelligence production. Section 4.3 of the document provides the following:

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, behavioral 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 permanent impairment).¹⁴²

Also, section 4.9 of the 2006 DoD Instructions provides that “medical personnel shall not be used to supervise, conduct, or direct interrogations.”¹⁴³ However, BSCT physicians are an exception to this rule.¹⁴⁴ Thus, they are authorized to “supervise, conduct or direct interrogations.”¹⁴⁵ Consequently, the Pentagon’s current policy regarding the practice of physician participation in interrogations clashes with the new ethical guidelines of the AMA and APA.

B. The AMA’s Position on Physician Participation in Interrogation

In June 2006, the AMA adopted Opinion 2.068 entitled “Physician Participation in Interrogation.” Both Opinion 2.068 and the

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² DEP’T OF DEF., *supra* note 135, at 3.

¹⁴³ *Id.* at 5.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

AMA's Council on Ethical and Judicial Affairs' report on Physician Participation in Interrogations ("CEJA Report") clarify the ethics regarding physician participation in interrogations. In addition, they both effectively address all four allegations of medical complicity in the mistreatment of detainees held in U.S. detention facilities. As mentioned above, the four allegations are (1) interrogators access to detainees' medical records; (2) the use of physicians to medically clear detainees for coercive and psychological interrogations; (3) the use of physicians as behavior consultants and advisors in conducting and monitoring interrogations; and (4) military physicians' failure to report abuses at U.S. detention facilities. Moreover, both Opinion 2.068 and the CEJA Report discuss how military physicians should deal with their dual loyalty dilemma, which is the conflict between their professional duties to the detainee-patient and their commitment to the national security of the United States.¹⁴⁶

1. Confidentiality

Regarding the practice of military physicians sharing detainees' medical records with interrogators, Opinion 2.068(1) provides that the physician must inform the detainee of the extent to which interrogators may have access to the detainee's medical records.¹⁴⁷ Similarly, the CEJA Report provides that military physicians are ethically required to warn their detainee-patients that "the information they provide for the medical record is accessible to facility authorities."¹⁴⁸ Fortunately, the 2006 DoD Instructions comply with Opinion 2.068(1), for the former provides in section 4.4 that "[d]etainees shall not be given cause to have incorrect expectations of privacy or confidentiality regarding their medical records and communications."¹⁴⁹ Thus no tension exists between the current medical practices at U.S. detention facilities and the AMA's Code of Ethics over the issue of confidentiality.

2. Using Physicians to Medically Clear Detainees for Harsh Interrogation

The CEJA Report addresses the concerns over the use of physicians to medically clear detainees for aggressive interrogations. The

¹⁴⁶ Singh, *supra* note 130, at 573.

¹⁴⁷ CODE OF MEDICAL ETHICS, *supra* note 9, 2.068(1), at 30.

¹⁴⁸ AM. MED. ASS'N, CEJA REP. 10-A-06, PHYSICIAN PARTICIPATION IN INTERROGATION 5 (2006), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_10a06.pdf.

¹⁴⁹ DEP'T OF DEF., *supra* note 135, at 3.

CEJA Report allows physicians to ask detainees questions regarding their health in order to determine their medical fitness and mental capacities. However, those same physicians cannot take part in deciding whether a detainee should be interrogated because such decisions are unrelated to the practice of medicine or to the health interests of the detainee.¹⁵⁰ Furthermore, Opinion 2.067, entitled "Torture," which was enacted in December 1999, already provides that physicians may treat detainees if doing so is in the best interest of their health, "but physicians should not treat individuals to verify their health so that torture can begin or continue."¹⁵¹ Since some of the interrogation techniques are viewed as "tantamount to torture,"¹⁵² the Pentagon should end the practice of using physicians to medically clear detainees for interrogation in order to comply with principles of medical ethics.

3. Physicians Participating in Interrogation

Opinion 2.068 does permit physicians to develop interrogation strategies so long as they are for general training purposes and do not cause physical or mental harm.¹⁵³ However, regarding the practice of physician participation in the interrogation, Opinion 2.068(2) provides that "[p]hysicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession."¹⁵⁴ Moreover, Opinion 2.068(3) provides that a "[p]hysician must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation[s]."¹⁵⁵ Thus, the AMA has made it clear that BSCT physicians are ethically required to avoid supervising, conducting and directing interrogations even if the Pentagon authorizes it.

Opponents of Opinion 2.068(2) and (3) might argue that doctors should remain involved in interrogations because interrogation relies on psychological manipulations which can cause the detainee to feel stress, anxiety, and other forms of discomfort.¹⁵⁶ Thus, the Defense Department should continue to involve physicians in interrogations so

¹⁵⁰ CEJA REP. 10-A-06, *supra* note 148, at 6.

¹⁵¹ CODE OF MEDICAL ETHICS, *supra* note 9, 2.067, at 29.

¹⁵² Lewis, *supra* note 23.

¹⁵³ CODE OF MEDICAL ETHICS, *supra* note 9, 2.068(4), at 30.

¹⁵⁴ *Id.* 2.068(2), at 30.

¹⁵⁵ *Id.* 2.068(3), at 30.

¹⁵⁶ CEJA REP. 10-A-06, *supra* note 148, at 4.

that the physician can act as a "safeguard" in order to make sure that the interrogations do not become abusive.¹⁵⁷ However, supporters of Opinion 2.068(2) provide three counterarguments for the claim that doctors should act as "safeguards" during interrogations.

First, physicians are trained to serve as healers. They simply do not have any training for this "safeguarding" function.¹⁵⁸ Physicians are only qualified to determine whether pain has been inflicted as a result of coercive interrogations.¹⁵⁹ They cannot predict whether an interrogator will or will not cause harm.¹⁶⁰ Second, the proximity of physicians in interrogation settings carries significant risk.¹⁶¹ If a physician monitors an interrogation, then the interrogator might believe that he can escalate the use of force against the detainee until the physician intervenes.¹⁶² Thus, a physician's presence during the interrogation for "safeguarding" purposes could lead to the undesired outcome of physicians calibrating "the degree of harm to be 'acceptably' inflicted during an interrogation."¹⁶³ Third, both U.S. federal law and the Geneva Conventions already prohibit the use of torture to extract information,¹⁶⁴ which makes the presence of a physician to act as a "safeguard" against abusive interrogators unnecessary.¹⁶⁵ The federal anti-torture statute, 18 U.S.C. §2340(1), defines "torture" as "an act committed by a person acting under the color of the law specifically intended to inflict severe physical or mental pain or suffering"¹⁶⁶ The anti-torture statute goes on to define "severe mental pain or suffering" as "the prolonged mental harm caused by or resulting from . . . procedures calculated to disrupt profoundly the senses or the personality. . . ."¹⁶⁷ Thus, since the use of sensory deprivation interrogation techniques, such as sleep deprivation and prolonged isolation, can "disrupt profoundly the senses or the personality" of a detainee,¹⁶⁸ the presence of a physician will not make these interrogation methods more compliant with 18 U.S.C. §2340A.

¹⁵⁷ See Rubenstein, *supra* note 85, at 738-39.

¹⁵⁸ *Id.* at 739.

¹⁵⁹ CEJA REP. 10-A-06, *supra* note 148, at 5.

¹⁶⁰ *Id.*

¹⁶¹ Bloche & Marks, *supra* note 32, at 8.

¹⁶² CEJA REP. 10-A-06, *supra* note 148, at 4; *see also* Bloche & Marks, *supra* note 32, at 8.

¹⁶³ Rubenstein, *supra* note 85, at 739.

¹⁶⁴ PHYSICIANS FOR HUMAN RIGHTS, *supra* note 35, at 101-06.

¹⁶⁵ CEJA REP. 10-A-06, *supra* 148, at 5.

¹⁶⁶ 18 U.S.C. § 2340(1) (2006).

¹⁶⁷ 18 U.S.C. § 2340(2).

¹⁶⁸ PHYSICIANS FOR HUMAN RIGHTS, *supra* note 35, at 104.

Furthermore, the Geneva Conventions, which the United States has signed, provide, in relevant part:

No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to unpleasant or disadvantageous treatment of any kind.¹⁶⁹

Since interrogators are required to comply with 18 U.S.C. §2340A and the Geneva Conventions, medical monitoring is not required for lawful interrogation.¹⁷⁰ Thus, due to the validity of these three arguments in favor of a prohibition of physician participation in interrogations, it is no surprise that Opinion 2.068(3) bars physicians from monitoring interrogations even with the intention of intervening to prevent abuse.¹⁷¹

4. Physicians Failing to Report Abuse

Opinion 2.068 also addresses military physicians' failure to report detainee abuses in Guantanamo and Abu Ghraib. Opinion 2.068(5) requires physicians to report abuse or suspicions of abuse to the appropriate authorities.¹⁷² Furthermore, if the "authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations."¹⁷³ With the recent enactment of Opinion E-2.068(5), hopefully military physicians will feel emboldened to act as whistleblowers in the event that they discover that detainees were either physically or mentally abused during interrogations.

5. Dual Loyalty Issues

As mentioned above, the Bush Administration believes that BSCT physicians are not acting as physicians, but as combatants, when they direct interrogations. The Bush Administration tried to deny the "physicianhood" of BSCT physicians and relegated them exclusively to intelligence gathering responsibilities so that the BSCT physicians

¹⁶⁹ Geneva Convention Relative to the Treatment of Prisoners of War art. 17, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135.

¹⁷⁰ CEJA REP. 10-A-06, *supra* note 148, at 5.

¹⁷¹ CODE OF MEDICAL ETHICS, *supra* note 9, 2.068(3), at 30.

¹⁷² *Id.* 2.068(5), at 31.

¹⁷³ *Id.*

owe their loyalty exclusively to the nation's national security.¹⁷⁴ However, Opinion 2.068 explains that if physicians engage in an activity that requires them to use their medical expertise, then the AMA's Principles of Medical Ethics apply.¹⁷⁵ Since BSCT physicians use their medical expertise to increase the stress and anxiety of detainees, they must comply with the AMA's Code of Ethics, which provides clear instructions for physicians who confront dual loyalties.

The Principles of Medical Ethics provide that physicians owe their obligations to their "patients first and foremost."¹⁷⁶ However, not all physicians work in the clinical setting. Some physicians, such as forensic psychiatrists or occupational health physicians, confront dual loyalties in which they have to balance the medical interest of the individuals with whom they interact with the interests of the third parties to whom the physicians are accountable.¹⁷⁷ For example, if an employer hires a physician who has to examine the health of an employee, the physician has certain ethical obligations to the employee as well as contractual duties to the employer.¹⁷⁸ In that setting, the AMA's Code of Ethics explains that physicians must not fulfill responsibilities to the employer in a manner that harms the medical condition of the employee.¹⁷⁹ The same principle applies to physicians in the detention facility setting. While Pentagon officials argue that BSCT physicians are not bound by physicians' ethical obligations to detainees because they do not treat them, "various Opinions in the AMA's Code of Medical Ethics suggest that physician interactions under the authority of third parties are governed by the same ethical principles as interactions involving patients."¹⁸⁰ Thus, all military physicians – whether they are in charge of detainees' medical care or are in charge of intelligence gathering – are ethically required to avoid inflicting physical or mental harm on detainees. Since BSCT physicians mostly consist of psychiatrists, the APA's newly enacted ethical reforms regarding psychiatric participation in interrogations merits attention.

¹⁷⁴ Bloche & Marks, *supra* note 4, at 5.

¹⁷⁵ CODE OF MEDICAL ETHICS, *supra* note 9, 2.068, at 30.

¹⁷⁶ CODE OF MEDICAL ETHICS, *Preamble*, *supra* note 102, at xvi.

¹⁷⁷ CEJA REP. 10-A06, *supra* note 148, at 4.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* at 5.

C. APA's Position on Physician Participation in Interrogations

In May 2006, The APA promulgated a Position Statement titled "Psychiatric Participation in Interrogation of Detainees ("Position Statement"). The Position Statement addresses three issues relating to interrogations: confidentiality of detainees' medical records, psychiatric participation in interrogations, and psychiatrists' obligations to report abuse.

As mentioned before, if the detainee has no expectations of confidentiality, both the AMA's Opinion 2.068 and the 2006 DoD Instructions allow military physicians to share detainee medical records with interrogators. However, the APA finds this practice to be unethical, for the Position Statement provides "[p]sychiatrists should not disclose any part of the medical records of any patient, or information derived from the treatment relationship, to persons conducting interrogation of the detainee."¹⁸¹ The only exception to this rule is when a psychiatrist learns that the detainee may pose a significant harm to himself or to others.¹⁸² The APA prohibits psychiatrists from sharing detainees' medical records with interrogators for two reasons. First, military psychiatrists who are responsible for the mental health of detainees owe their primary obligation to their patient-detainee.¹⁸³ Since sharing medical information with interrogators may lead to interrogators exploiting a detainee's mental ailments, the well-being of the detainee would be compromised. Second, providing interrogators with a detainee's psychiatric medical record would "indirectly" and "covertly" facilitate interrogation,¹⁸⁴ a practice that the APA prohibits.

Like the AMA, the APA allows psychiatrists to provide interrogators with general information regarding mental illnesses and the possible health effects of interrogations.¹⁸⁵ However, on the issue of psychiatric participation in interrogations, the APA's Position Statement provides that "[n]o psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian . . . authorities, whether in the United States or elsewhere."¹⁸⁶ Unlike the AMA, the APA defines "direct participation," which clears up any ambiguity. The APA states that "[d]irect participation includes being present in the interrogation room, asking or suggesting questions, or

¹⁸¹ Am. Psychiatric Ass'n, *supra* note 10.

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *See id.*

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

advising authorities on the use of specific techniques of interrogation with particular detainees.”¹⁸⁷ Thus, while both the AMA and APA allow their members to provide general advice and training to interrogators, both organizations make it clear that physicians are ethically required to stay out of the interrogation room and are barred from giving interrogators advice on specific interrogation techniques for specific detainees.¹⁸⁸ Furthermore, like the AMA’s Code of Ethics, the APA requires psychiatrists who have knowledge or suspect incidents of torture to promptly report this information to an official who is in a position to take corrective action.¹⁸⁹

D. International Medical Societies’ Positions on Physician Participation in Interrogations

Both the WMA and the UN Principles of Medical Ethics relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“UN Principles of Medical Ethics”) make it clear that the practice of physician participation in interrogations violates principles of medical ethics.¹⁹⁰

The WMA has held that “[m]edical ethics in times of armed conflict is identical to medical ethics in times of peace. . . .”¹⁹¹ Moreover, The WMA explains that the primary function of the medical profession is to preserve health. Therefore, physicians may not employ a detainee’s health information in any way to facilitate interrogations.¹⁹² In addition, the WMA provides that physicians may not perform medical exams on prisoners in order to determine whether the prisoner is fit for aggressive interrogations, because physicians are only authorized to perform diagnostic procedures if they contribute to the patient’s well-being.¹⁹³ Also, the WMA prohibits the practice of physician participation in interrogations.¹⁹⁴ Lastly, the WMA requires

¹⁸⁷ *Id.*

¹⁸⁸ Marks, *supra* note 128, at 726.

¹⁸⁹ Am. Psychiatric Ass’n, *supra* note 10.

¹⁹⁰ WORLD MED. ASS’N, THE WORLD MEDICAL ASSOCIATION REGULATIONS IN TIMES OF ARMED CONFLICT (2006), *available at* <http://www.wma.net/e/policy/a20.htm>. See also UN Principle of Medical Ethics, Principle 2, U.N. Doc. 37/194 (Dec. 18, 1982), *available at* http://www.unhchr.ch/html/menu3/b/h_comp40.htm.

¹⁹¹ WORLD MED. ASS’N, *supra* note 190.

¹⁹² *Id.*

¹⁹³ *Id.*

¹⁹⁴ WORLD MED. ASS’N, *supra* note 7.

physicians to document incidents of torture or mistreatment in a medical record.¹⁹⁵

In December 1982, the United Nations adopted the UN Principles of Medical Ethics.¹⁹⁶ Regarding the issue of medically clearing detainees for coercive and psychological interrogation, the UN Principles of Medical Ethics provide, in relevant part, that physicians may not “certify . . . or . . . participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health.”¹⁹⁷ This document also provides that a physician may not “be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.”¹⁹⁸ Since physicians can have no other relationship with detainees other than physician-patient under the UN Principles of Medical Ethics, military physicians should never assume the role of physician-interrogator. On the specific issue of physician participation in interrogations, the UN Principles of Medical Ethics provides that “it is a contravention of medical ethics for health personnel, particularly physicians . . . to apply their knowledge and skills in order to assist in the interrogation of prisoners or detainees in a manner that may adversely affect the physical or mental health . . . of such prisoners or detainees.”¹⁹⁹ Thus, domestic and international codes of medical ethics collectively agree that the practice of physician participation in interrogations constitutes improper and unethical medical misconduct.

E. Concluding Remarks Regarding Ethics

The fundamental ethical principle that guides the medical profession is to never use medical skills to cause harm.²⁰⁰ Unfortunately, the Bush Administration ignores this very basic ethical precept as it continues to employ physicians to supervise, direct, and conduct abusive interrogation plans that include sleep deprivation, prolonged periods of isolation, and hooding. Both the AMA and APA deserve

¹⁹⁵ WORLD MED. ASS'N, ON THE RESPONSIBILITY OF PHYSICIANS IN THE DOCUMENTATION AND DENUNCIATION OF ACTS OF TORTURE OR INHUMAN OR DEGRADING TREATMENT, (October 2007), *available at* <http://www.wma.net/e/policy/t1.htm>.

¹⁹⁶ Principles of Medical Ethics, G.A. Res. 37/194, U.N. Doc. A/RES/37/194 (Dec. 18, 1982), *available at* <http://www.un.org/documents/ga/res/37/a37r194.htm>.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ CEJA REP.10-A-06, *supra* note 148, at 7.

much praise for enacting new ethical guidelines that strictly prohibit the practice of physician participation in interrogations. However, these reform efforts are ineffective if medical societies do not work hard to change the law as well. Physicians have an ethical obligation to advance the interest of patients, including changing laws that conflict with patient interests.²⁰¹ Therefore, medical societies should convince lawmakers to expressly prohibit the practice of physician participation in interrogations either explicitly or implicitly.

III. STATUTORY APPROACHES TO PRECLUDE THE INVOLVEMENT OF PHYSICIANS IN INTERROGATIONS

As mentioned in the Introduction, state lawmakers have at least three legislative options to select from in restricting the practice of physician participation in interrogations. The best option is to pass a law that would explicitly prohibit physician participation in interrogations. This would remove any doubt as to whether such practice is permitted. An explicit statute would satisfy any due process concerns raised by a potential offending licensee by providing unequivocal notice. Another option is to enact a statute that provides that any violation of the AMA's Code of Ethics constitutes grounds to revoke or suspend a physician's medical license. This statutory measure, however, is only effective if a state medical board chooses to exercise its discretion to enforce Opinion 2.068. A third option, and perhaps the least effective, is to enact a resolution that condemns physicians that take part in interrogations. While a resolution is not legally binding like a statute, it may nevertheless be forceful enough to deter licensed physicians from engaging in interrogation activities.

A. Option 1: A Statute that Explicitly Prohibits Physician Participation in Interrogations

To understand the rationale for enacting a statute that strictly bars physicians from playing a role in interrogations, one must examine the AMA's prior efforts in enforcing its ethical ban on physician participation in execution by lethal injection. In 1980, the AMA enacted Opinion 2.06, which prohibits physician participation in executions of prisoners.²⁰² Before analyzing the AMA's failure to enforce Opinion 2.06, one must acknowledge that the controversy regarding physician participation in lethal injection executions is distinguishable from the

²⁰¹ CODE OF MEDICAL ETHICS, *Preamble*, *supra* note 102, at xxvii.

²⁰² CODE OF MEDICAL ETHICS, *supra* note 9, 2.06, at 20-21.

debate over physician participation in interrogations in two important respects. First, while most states have statutes that allow physicians to participate in executions,²⁰³ no state has enacted a statute that permits physicians to take part in interrogations. Second, while states have traditionally assumed the responsibility of executing convicted prisoners, the federal government has handled the obligation to interrogate detainees that are suspected of plotting acts of terrorism against the country.

However, these differences do not preclude the AMA from employing the lesson it learned from its experience with lethal injection executions to enforce Opinion 2.068. On the contrary, an examination of the AMA's ineffective enforcement of Opinion 2.06 is highly relevant because the practice of physician participation in execution shares at least three common attributes with the practice of physician participation in interrogation. First, in both practices, the participating physician often chooses to keep his or her identity anonymous.²⁰⁴ This is because the medical community views physician participation in either execution or interrogation to be completely abhorrent, whereas the law may not as strongly object.²⁰⁵ Second, in both practices, the government instructs the physician to carry out a procedure that conflicts with the medical profession's fundamental objective. In facilitating executions by lethal injection, the physician violates his basic ethical commitment to preserve life "when there is hope of doing so. . . ." ²⁰⁶ Similarly, by participating in coercive and abusive interrogations, the physician violates the medical profession's basic ethical principle to "do no harm."²⁰⁷ Third, in both executions and interrogations, physicians are asked to participate in activities that are highly controversial. As Christopher J. Levy notes, the debate regarding physician participation in execution "has become as controversial as the death penalty itself."²⁰⁸ Similarly, the debate over whether physicians should participate in interrogations is no less controversial than some of the questionable interrogation techniques used against the detainees, such as waterboarding.²⁰⁹ Thus, in light of these

²⁰³ Atul Gawande, *When Law and Ethics Collide – Why Physicians Participate in Executions*, 354 NEW ENG. J. MED. 1221, 1223 (2006) (stating that 35 states allow physicians to participate in executions).

²⁰⁴ *Id.* at 1221 (explaining that courts have agreed to keep the identity of two willing anesthesiologists anonymous).

²⁰⁵ See CODE OF MEDICAL ETHICS, *supra* note 9, 2.06, at 20-21.

²⁰⁶ *Id.*

²⁰⁷ CEJA REP. 10-A-06, *supra* note 148, at 7; see also Levy, *supra* note 2, at 268 (explaining that an important tenet of the Hippocratic Oath is to "[d]o no harm").

²⁰⁸ Levy, *supra* note 2, at 261.

²⁰⁹ See Scott Shane, *Remarks on Torture May Force New Administration's*

profound similarities, examining the legal barriers that obstructed the AMA from enforcing Opinion 2.06 may provide insight into ways to successfully enforce Opinion 2.068.

The AMA's history in enforcing Opinion 2.06 demonstrates that without the explicit backing of a state statute, Opinion 2.068 is toothless and incapable of prohibiting physicians from taking part in interrogations. The AMA has had difficulty enforcing Opinion 2.06 primarily because some states have laws that conflict with the generally accepted ethical prohibition of physician participation in executions. Of the 38 death-penalty states, 35 explicitly allow physician participation in executions.²¹⁰ In fact, 17 states require physicians to participate in executions.²¹¹ Moreover, it has been reported that some states have offered to protect physicians that have participated in executions from license challenges by providing them with immunity for violating principles of medical ethics and promising to keep their identities anonymous.²¹² Thus, the important lesson to learn from the AMA's attempts to prohibit members of its profession from participating in executions is that sometimes the AMA needs the explicit backing of state law to enforce certain ethical guidelines.

Thus far, two death-penalty states have prohibited their licensed physicians from taking part in lethal injection executions: Kentucky and Illinois.²¹³ The Kentucky Code provides that "[n]o physician shall be involved in the conduct of an execution except to certify cause of death provided that the condemned is declared dead by another person."²¹⁴ The Illinois Code imposes a similar restriction, providing that "[t]he Department of Corrections shall not request, require, or allow a health care practitioner licensed in Illinois, including but not limited to physicians and nurses, regardless of employment, to participate in an execution."²¹⁵ By choosing to explicitly legislate against the practice of physician involvement in executions rather than remaining silent on the matter, the Kentucky and Illinois state legislatures have made it clear that their respective medical licensing boards have the authority to discipline their physicians for

Hand, N.Y. TIMES, Jan. 17, 2009, at A12. During his confirmation hearing, Eric Holder, then attorney-general designate, testified that "waterboarding is torture." *Id.* On the other hand, Attorney General Michael B. Mukasey refused to explicitly state that waterboarding is torture during his confirmation hearings in 2007. *Id.*

²¹⁰ Gawande, *supra* note 203, at 1223.

²¹¹ *Id.*

²¹² *Id.*

²¹³ *Id.* at 1229.

²¹⁴ KY. REV. STAT. ANN. § 431.220(3) (West 2006).

²¹⁵ 725 ILL. COMP. STAT. ANN. 5/119-5(d-5) (West Supp. 2008).

taking part in executions. The approach taken by the Kentucky and Illinois legislatures to address the issue of physician participation in executions should be emulated to resolve the issue concerning physician participation in interrogation.

The need for a statute that explicitly prohibits physician participation in executions was also evident in the case law concerning the license challenges of physicians that participated in executions. Thus far, two states have had cases in their state courts involving the license challenges of physicians taking part in executions: Georgia and North Carolina.

In the Georgia case, *Zitrin v. Georgia Composite State Board of Medical Examiners*, a group of academic physicians, led by Arthur Zitrin, filed a complaint against the Georgia Composite State Board of Medical Examiners ("Georgia Medical Board") for its refusal to open disciplinary investigations of Georgia doctors who took part in executing inmates by lethal injection.²¹⁶ Under Georgia law, the Georgia Medical Board has the authority to discipline physicians licensed in Georgia for unethical conduct that harms the public.²¹⁷ Zitrin argued that physicians who took part in the lethal injection procedures are subject to discipline under Georgia law because such conduct violates the Hippocratic Oath and the AMA's Code of Ethics.²¹⁸ Zitrin sought a declaratory judgment that the practice of physician participation in executions violates OCGA §43-34-37(a)(7)²¹⁹ and 43-34-37(a)(10).²²⁰ However, the court held that Zitrin lacked standing to pursue a declaratory judgment.²²¹ To obtain a declaratory judgment under Georgia law, the plaintiff must show that he "is in a position of uncertainty as to an alleged right. . . ."²²² Zitrin argued that he and his colleagues were "in a position of uncertainty because they could be subject to disciplinary proceedings" if they ever

²¹⁶ *Zitrin v. Ga. Composite State Bd. of Med. Examiners*, 653 S.E.2d 758, 760 (Ga. Ct. App. 2007).

²¹⁷ GA. CODE ANN. § 43-34-37(a)(7) (2008).

²¹⁸ *Zitrin*, 653 S.E.2d at 760.

²¹⁹ Under this statute, the Georgia Medical Board has the authority to discipline those physicians who "[e]ngaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public." § 43-34-37(a)(7). This statute defines "unprofessional conduct" as "any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice. . . ." *Id.*

²²⁰ Georgia law authorizes the Georgia Medical Board to discipline any Georgia physician for violating the law, rule, or regulation of the practice of medicine. GA. CODE ANN. § 43-34-37(a)(10) (2008).

²²¹ *Zitrin*, 653 S.E.2d at 763.

²²² *Id.* at 762.

decided to participate in executions.²²³ However, the court rejected this argument for two reasons. First, since Zitrin and his colleagues believed that the Hippocratic Oath and AMA Code of Ethics “forbid such participation, it [was] clear” that they would never take part in executions.²²⁴ Second, the Georgia Medical Board’s decision assured Zitrin and his colleagues that no physician would ever be disciplined in Georgia for his or her involvement in an execution. Consequently, the court denied Zitrin’s complaint for lack of standing.

The facts in *Zitrin* demonstrate that medical boards may exercise their discretion in refusing to enforce specific provisions of the AMA’s Code of Ethics. State medical boards are far less likely to enforce Opinion 2.06 if state law requires physicians to be present in executions.²²⁵ To overcome such apathy, state law should be amended so that it conforms to the AMA’s Code of Ethics. Hence, the outcome in *Zitrin* suggests that the best approach to overcome a state medical board’s reluctance in enforcing certain provisions of the AMA Code of Ethics, such as Opinion 2.068, is to enact a statute that explicitly prohibits the unethical conduct. Such a statute would embolden passive medical boards to aggressively discipline their physician-licensees for participating in interrogations. Moreover, state courts are more likely to defer to a state medical board’s decision to challenge the license of a physician who took part in interrogations if the state legislature bars such conduct. This was the lesson learned from a reviewing court’s decision in *North Carolina Dept of Correction v. North Carolina Medical Board*.

Unlike the Georgia Medical Board, the North Carolina Medical Board wanted to discipline North Carolina physicians that participated in executions even though North Carolina’s death penalty statute requires a “surgeon or physician” to be present during an execution.²²⁶ Defying the state’s death penalty statute, the North Carolina Medical Board enacted a Position Statement declaring that physician involvement in executions constituted grounds for discipline because such conduct was a complete departure from the ethics of the medical profession.²²⁷ As a result, this made it difficult for the North Carolina

²²³ *Id.*

²²⁴ *Id.*

²²⁵ The Georgia Medical Board may have been reluctant to enforce Opinion 2.06 because Georgia law requires two physicians to be present during the execution of a convicted prisoner. GA. CODE ANN. § 17-10-41 (2008) (requiring “two physicians to determine when death supervenes”).

²²⁶ N.C. GEN. STAT. § 15-190 (2007).

²²⁷ Court Order, *supra* note 15, at 2-3.

Department of Corrections to carry out executions of convicted prisoners.

The North Carolina Medical Board in *North Carolina Dept of Correction v. North Carolina Medical Board* argued that it had the statutory authority to penalize physicians within the state for “[u]nprofessional conduct, including, but not limited to, departure from . . . the ethics of the medical profession. . . .”²²⁸ Accordingly, since the practice of physician participation in executions violates medical ethics, the North Carolina Medical Board argued that it had the authority to use license challenges to end the practice. However, the court ruled otherwise.

The court held that the North Carolina Medical Board did not have authority to use license challenges as a means to prevent doctors from participating in executions because an execution carried out in accordance with North Carolina’s death penalty statute is not a “medical event or medical procedure.”²²⁹ When complying with North Carolina’s death penalty law, “physicians participating in executions, even if engaged in medical evaluations, examinations, assessments and procedures, are not subject to review or regulation by the Medical Board.”²³⁰ The court further held that while “the current effort by the Medical Board to prohibit physician participation in executions may well be viewed as humane and noble, such a decision rests entirely with the representatives elected by the citizens of this State, the North Carolina General Assembly.”²³¹ Consequently, the only way the North Carolina Medical Board can effectively enforce Opinion 2.06 is if the North Carolina legislature enacts a statute that explicitly prohibits physician participation in executions. Therefore, in the context of physician participation in interrogations, state courts may only permit a state medical board to discipline a physician for participating in an interrogation if such practice is explicitly prohibited by a statute.

Currently, New York is the only state in the nation that has considered enacting legislation that explicitly prohibits physician participation in interrogation. On February 1, 2008, Assembly member Richard N. Gottfried introduced Assembly Bill 9891 to the New York State Legislature.²³² This bill provides that “[n]o health care professional shall engage, directly or indirectly, in any act which constitutes participation in, complicity in, incitement to, assistance in, planning or design of, or attempt or conspiracy to commit torture or improper

²²⁸ N.C. GEN. STAT. § 90-14(a)(6) (2007).

²²⁹ Court Order, *supra* note 15, at 4.

²³⁰ *Id.* at 5.

²³¹ *Id.* at 5.

²³² Assem. B. 9891, 231st Legis. Sess. (N.Y. 2008).

treatment of a prisoner."²³³ The bill's definition of "health care professionals" includes licensed physicians as well as other licensed health professionals.²³⁴ The bill also defines "[t]orture or improper treatment of a prisoner" as "torture, cruel and unusual, or degrading, physical or mental treatment of a person as or in connection with . . . interrogation . . . of the person . . . in violation of applicable treaties of international law; federal, state or local law; or international, national or state health care professional standards. . . ."²³⁵ The bill's definition of "prisoner" is broad enough to include detainees at US detention facilities.²³⁶

Like the ethical guidelines of the AMA and APA, the New York bill allows physicians to collaborate with interrogators for "general training purposes."²³⁷ However, the bill prohibits health professionals from using their expertise to "assist in the punishment, detention, incarceration, interrogation, intimidation or coercion of a prisoner in a manner that may adversely affect the physical or mental health or condition of the prisoner. . . ."²³⁸ Under the bill, physicians are also barred from evaluating or treating a prisoner "so that torture or improper treatment of the prisoner may begin or be resumed."²³⁹ In regards to interrogation activities, this bill is very unambiguous in its ban on the practice of physician participation in interrogation. It provides that "no health care professional shall participate in the interrogation of a prisoner, including being present in the interrogation room, asking or suggesting questions, advising on the use of specific interrogation techniques, or monitoring interrogation with the intention of intervening in the process."²⁴⁰ The bill also establishes a duty to report any occurrences or suspicions that "torture or the improper treatment of a prisoner has taken . . . place."²⁴¹ To establish a violation under this bill, it must be proven that "the actor knew or reasonably should have known the nature of his or her conduct."²⁴²

The bill also addresses jurisdictional issues by providing that "[t]his section shall apply to conduct taking place within or outside

²³³ *Id.* § 2.

²³⁴ *Id.* § 1(a).

²³⁵ *Id.* § 1(c).

²³⁶ *See id.* § 1(d) (broadly defining the term "[p]risoner" to "mean[] any person who is subject to punishment, detention, incarceration, interrogation, intimidation or coercion").

²³⁷ *Id.* § 2(e).

²³⁸ *Id.* § 2(c)(i).

²³⁹ *Id.* § 2(c)(ii).

²⁴⁰ *Id.* § 2(e).

²⁴¹ *Id.* § 4.

²⁴² *Id.* § 3.

New York state, and without regard to whether the conduct is committed by a governmental or non-governmental entity or under actual or asserted color of law.”²⁴³ Some may argue that New York State’s jurisdiction should be confined to its borders, and that it definitely should not extend to the affairs of the federal government.²⁴⁴ However, by having the authority to grant a license, the state has the right to regulate the professional behavior and conduct of the person to whom it grants a license.²⁴⁵ Moreover, it is not uncommon for a state to revoke a person’s professional license for out of state misconduct.²⁴⁶ Thus, if lawmakers decide to pass a bill that is similar in substance to AB 9891, then the state medical board should have the jurisdictional authority to discipline its licensees for participating in the interrogation of detainees held at Guantanamo or other US military sites.

The last action taken on AB 9891 was when the Assembly referred it to the New York State Assembly Rule’s Committee on June 17, 2008.²⁴⁷ Even though both Democrats and Republicans in the New York State Assembly have co-sponsored this bill,²⁴⁸ it did not pass before the end of the final year of the 231st legislative session.²⁴⁹ Because lawmakers failed to pass AB 9891 by the end of 2008, it automatically died.²⁵⁰ However, sponsors of this bill intend to reintroduce a new bill in the new legislative session.²⁵¹ This new bill will be made easier to read and similar in substance to AB 9891.²⁵² Since the Democrats in New York will control both the full Legislature and the governor’s office in 2009, there is a good chance that a bill that ex-

²⁴³ *Id.* § 5.

²⁴⁴ *See, e.g., id.* § 1 (“The legislature is mindful that there are limits on New York state’s jurisdiction relating to conduct outside the state or under federal authority.”).

²⁴⁵ N.Y. State Assembly, *supra* note 6.

²⁴⁶ *Id.*

²⁴⁷ FED’N OF STATE MED. BOARDS, FSMB LEGISLATIVE SERVICES REPORT 78 (2008), http://www.fsmb.org/pdf/Legislative_Services_Report_March_2008.pdf.

²⁴⁸ N.Y. State Assembly, *supra* note 6.

²⁴⁹ Telephone Interview with Monica Miller, Legislative Assistant, New York State Assemblymember Richard N. Gottfried, 75th Assembly District (Jan. 12, 2009). Ms. Miller explained that if a bill is introduced to the New York State Assembly during an even year of a legislative term and the bill does not pass within such term, then the bill dies immediately. *Id.* AB 9891 was introduced in February 2008, an even year. *Id.* Ms. Miller also explained that since there was no comparable bill in the State Senate, there was not enough time for lawmakers to enact it before the end of 2008. *Id.*

²⁵⁰ *Id.*

²⁵¹ *Id.*

²⁵² *Id.*

plicitly prohibits New York State licensed health professionals from participating in interrogation will be enacted into law before the end of 2009.²⁵³

Since the 2006 DoD Instructions permit physicians stationed at US military sites to “supervise, conduct or direct interrogations,”²⁵⁴ the burden rests with state lawmakers to enforce AMA’s ban on physician participation in interrogations. To do so, state lawmakers must enact a statute that explicitly forbids the practice of physician participation in interrogation. The unsuccessful license challenges in *Zitrin* and *North Carolina Dept of Correction v. North Carolina Medical Board* indicate that provisions of the AMA Code of Ethics require the explicit backing of state law to guarantee enforcement. If state law either conflicts with Opinion 2.068 or is silent on the issue of physician participation in interrogation, then state medical licensing boards will have difficulty enforcing Opinion 2.068. Consequently, state lawmakers should consider adopting the same bill that was introduced to the New York State Legislature to make sure that all physicians comply with the widely accepted ethical ban on physician participation in interrogations.

B. Option 2: Convincing States to Incorporate the AMA’s Code of Ethics into State Medical Licensing Statutes

The best approach to prevent doctors from taking part in interrogations is to adopt a law that explicitly bars physicians from participating in interrogations, but this approach is also the most difficult to effectuate. Legislators may not pay attention to the issue of physician participation in interrogation for two reasons. First, in today’s political climate, any restrictions imposed on the Executive Branch’s ability to obtain military intelligence from detainees held in Guantanamo may cause political backlash. No lawmaker wants the public to perceive him or her as weak on terror. Second, the number of doctors from any particular state that actually participates in interrogation is probably insignificant. Clearly, if the issue of physician participation in interrogation does not substantially impact a state or its constituents, the state’s lawmakers will have little motivation to address the issue. In fact, the New York State Assembly probably allowed AB 9891 to lapse before the end of the legislative term because New York lawmakers did not view the issue of physician participation in interrogation as pressing as other matters. However, the absence of a statute that explicitly prohibits physician participation in interrogations does

²⁵³ *Id.*

²⁵⁴ DEP’T OF DEF., *supra* note 134, at 3.

not necessarily mean that a state medical board is powerless in enforcing Opinion 2.068. In states that have adopted the AMA's Code of Ethics, the state medical board should have the authority to discipline licensees for violating Opinion 2.068.

Ohio is one of three states in the nation that expressly empowers the state medical board to discipline physicians for conduct that violates the AMA's Code of Ethics.²⁵⁵ Under Ohio Revised Code §4731.22(B)(18), the Ohio Medical Board ("Board") is authorized to limit, revoke, or suspend a physician's license to practice medicine in Ohio for a "violation of any provision of a code of ethics of the American [M]edical [A]ssociation . . . or any other national professional organizations that the board specifies by rule."²⁵⁶ As a result of this statute, Ohio courts have shown profound deference to the Board's decisions to punish licensees for conduct that does not expressly violate the law, but may violate the AMA's Code of Ethics. Moreover, even if a challenged conduct does not explicitly violate the AMA's Code of Ethics, the Board may still have the authority to discipline its licensees because Ohio courts have held that they will defer to the Board's interpretation of the Code of Ethics.

This authority first became evident in 1976 when the Eighth District rendered its holding in *State Medical Board of Ohio v. Samame*. There, two undercover journalists from the Cleveland Plain Dealer visited Dr. Samame on separate occasions to obtain a prescription for a drug called Quaalude. In both instances, Dr. Samame prescribed the requested drug without conducting a prior physical examination. The Board held that Dr. Samame's conduct violated R.C. §4731.22(F)²⁵⁷ and the AMA's Code of Ethics Sections 4, 6, 7, and 10. In response to these violations, Dr. Samame argued that nowhere in R.C. § 4731.22(F) or the AMA's Code of Ethics Sections 4, 6, 7, 10 is there a requirement to conduct a physical examination before issuing a prescription.²⁵⁸ Therefore, according to Dr. Samame, he did nothing illegal.²⁵⁹ Even though the above cited violations of the Ohio Revised Code and the AMA's Code of Ethics do not explic-

²⁵⁵ Hawaii and Kentucky are the other two. See HAW. REV. STAT. § 453-8(a)(9) (2007); KY. REV. STAT. ANN. § 311.597(4) (West 2008).

²⁵⁶ OHIO REV. CODE ANN. § 4731.22(B)(18) (LexisNexis 2000).

²⁵⁷ At the time the Eighth District heard this case, OHIO REV. CODE ANN. § 4731.22(F) provided that "[g]rossly unprofessional or dishonest conduct" included "[t]he violation of any provision of a code of ethics of a national professional organization as specified in this division. National Professional Organization means American medical association. . . ." *State Med. Bd. of Ohio v. Samame*, No. 35053, 1976 Ohio App. LEXIS 7458, at *6-7, (Ohio Ct. App. Aug. 26, 1976).

²⁵⁸ *Id.* at *8.

²⁵⁹ *Id.*

itly require a physician to conduct a physical examination before providing a patient with a prescription, Ohio's Eighth District deferred to the Board's decision to discipline Dr. Samame.²⁶⁰ The Eighth District held that "the power to interpret the code of ethics is within the board's discretion."²⁶¹ The only check on the Medical Board's discretion to interpret medical ethics is that the Medical Board's conclusions have to be "supported by reliable, probative and substantial evidence. . . ."²⁶² Thus, the outcome in *Samame* demonstrates the willingness of Ohio courts to defer to the Board's decision to discipline a physician for conduct that neither the law nor the AMA's Code of Ethics explicitly prohibit.

Like the Eighth District, the Ohio Supreme Court has also held that it will defer to the Board's interpretation of the technical and ethical standards of the medical profession.²⁶³ In *Pons v. Ohio State Medical Board*, the Board revoked the license of a physician who had sexual relations with a patient. The Board in *Pons* invoked R.C. 4731.22(B)(14) and (15), which authorized the Board to punish physicians for violating ethical standards adopted by the AMA.²⁶⁴ However, at the time of Dr. Pons's alleged offense, the AMA did not explicitly prohibit physicians from having sexual relations with patients. Not until 1991, which was long after the Board heard Dr. Pons's case, did the AMA's Council on Ethical and Judicial Affairs announce for the first time that sexual relations with a patient violate medical ethics.²⁶⁵ Despite the fact that neither the law nor the AMA had expressly proscribed physicians from having sexual relations with patients, *Pons* deferred to the Board's ruling that the physician's conduct violated the AMA's ethical standards.²⁶⁶

The court in *Pons* held that it will defer to the Board's interpretation of the technical and ethical standards of its profession²⁶⁷ because "a majority of the board members possess the specialized knowledge needed to determine the acceptable standard of general medical practice. Hence, the medical board is quite capable of interpreting technical requirements of the medical field and quite capable of determining when conduct falls below the minimum standard of care."²⁶⁸ In

²⁶⁰ *Id.* at *11-12.

²⁶¹ *Id.* at *11.

²⁶² *Id.* at *12.

²⁶³ *Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748, 751 (Ohio 1993).

²⁶⁴ *Id.* at 752.

²⁶⁵ *Id.* at 753 (Pfeifer, J., dissenting).

²⁶⁶ *Id.* at 752 (majority opinion).

²⁶⁷ *Id.* at 751.

²⁶⁸ *Id.* at 751-52 (citations omitted).

response to Dr. Pons's complaint that the Board was punishing him for something that was neither explicitly illegal nor unethical, the Ohio Supreme Court quoted *Leon v. Ohio Bd. of Psychology*, which held "[it] takes no citation of authority to safely state that sexual relations between any professional and a client . . . are universally prohibited by the ethical regulations of practically every profession."²⁶⁹

Thus, the holding in *Pons* reveals that Ohio courts will leave it up to the Board's discretion to interpret the AMA's ethical guidelines.²⁷⁰ Moreover, the facts in *Pons* are not as favorable as the facts involving a hypothetical disciplinary proceeding against an Ohio physician who participated in interrogation activities at Guantanamo. In *Pons*, the AMA did not explicitly provide that sexual relations with a patient constitutes unethical conduct when the Board first heard Dr. Pons's case. However, the AMA has explicitly declared that physician participation in interrogations violates a principle of medical ethics. Thus, under *Pons*, Ohio courts would most likely defer to the Board's decision to revoke the license of an Ohio physician who took part in interrogations at a U.S. military site. Therefore, if a state medical board decides to be proactive in enforcing Opinion 2.068, a medical licensing statute that adopts that the AMA's Code of Ethics may work as effectively as a statute that explicitly prohibits the practice of physician participation in interrogations.

Critics of the Ohio Supreme Court's ruling in *Pons* may argue that the Board should be required to show that a physician's conduct expressly violates a statute before it revokes his medical license,²⁷¹ Moreover, pursuing disciplinary measures against a physician for conduct that does not explicitly violate the law may violate the doctor's due process rights.²⁷² However, the Tenth District of Ohio addressed this concern in *Gladieux v. Ohio State Medical Board*. There, the Board took disciplinary action against Dr. Gladieux, a pediatrician, for having consensual sexual relations with at least seven mothers of his pediatric patients.²⁷³ The Board suspended Dr. Gladieux's license to practice medicine in Ohio for violating Principles I and IV of the AMA's Principle of Medical Ethics. Dr. Gladieux argued that the Board violated his due process rights because the medical

²⁶⁹ *Id.* at 752 (citing *Leon v. Ohio Bd. Of Psychology*, 590 N.E.2d 1223, 1226 (Ohio 1992)).

²⁷⁰ *Id.* at 751.

²⁷¹ *Id.* at 754 (Pfeifer, J., dissenting) (providing that it should "require a citation of authority to strip a person of his ability to practice his profession").

²⁷² *Gladieux v. Ohio State Med. Bd.*, 728 N.E.2d 459, 462-63 (Ohio Ct. App. 1999).

²⁷³ *Gladieux*, 728 N.E.2d at 461.

profession did not provide any written rules that explicitly prohibited a pediatrician from having sexual relations with the parent of a pediatric patient.²⁷⁴ Therefore, Dr. Gladieux argued that he lacked fair notice.²⁷⁵

The Tenth District disagreed, holding that in order for a statute to comply with the Due Process Clause of the Fourteenth Amendment, it must contain sufficient definiteness in the language and provide a person of ordinary intelligence with fair notice that certain conduct is prohibited.²⁷⁶ However, when a statute affects a select group of individuals with specialized knowledge of the regulated subject, "the degree of definiteness required to meet the due process requirements is measured by the common understanding of [that] group."²⁷⁷ Since members of the medical profession constitute a select group with a specialized understanding of the subject being regulated, due process requirements are relaxed.²⁷⁸ The Tenth District then relied on *Pons* to rule in favor of the Board. In both *Pons* and *Gladieux*, the AMA's ethical principles did not explicitly prohibit the regulated conduct, but both courts affirmed the Board's decision.²⁷⁹ Both courts held that the Medical Board did not exceed its statutory authority in finding that the defendants violated the AMA's ethical guidelines by having sexual relations with patients, because "reviewing courts must accord due deference to the board's interpretation of the technical and ethical requirements of its profession."²⁸⁰ Thus both *Pons* and *Gladieux* demonstrate that R.C. §4371.22(B)(18) provides the Board with sufficient statutory authority to discipline physicians for engaging in interrogation activities at US detention facilities since the Code of Ethics explicitly prohibits this practice.

In sum, if a state medical board wishes to enforce Opinion 2.068, then a medical licensing statute that adopts the AMA's Code of Ethics may provide it with sufficient legal authority to do so. In both *Pons* and *Gladieux*, the AMA Code of Ethics did not expressly prohibit the alleged offense, yet Ohio courts deferred to the Board's decision to discipline the offending physicians. Thus, if the Board ever decided to discipline an Ohio physician for participating in interrogations, the reviewing court would have to defer to the Board's

²⁷⁴ *Id.*

²⁷⁵ *Id.* at 463.

²⁷⁶ *Id.*

²⁷⁷ *Id.*

²⁷⁸ *Id.*

²⁷⁹ *Id.* at 463-64; *Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748, 752 (Ohio 1993).

²⁸⁰ *Gladieux*, 728 N.E.2d at 464.

decision under both *Pons* and *Gladieux* because the AMA has unequivocally barred the practice of physician participation in interrogation by enacting Opinion 2.068.

C. Option 3: Enacting a Resolution that Condemns the Use of Physicians for Interrogation Purposes

In response to allegations that California-licensed health professionals have taken part in torture or covering up torture at US military sites,²⁸¹ the California State Legislature enacted Senate Joint Resolution No. 19 ("SJR 19") on August 18, 2008. SJR 19 expresses the legislature's strong condemnation of the practice of physician participation in interrogation by laying out six important provisions.

First, SJR 19 provides that "California-licensed health professionals are absolutely prohibited from knowingly planning, designing, participating in, or assisting in the use of condemned techniques at any time and may not enlist others to employ these techniques to circumvent that prohibition. . . ."²⁸² Second, SJR 19 "requests" all relevant California agencies to inform their licensees that Common Article III of the Geneva Conventions, the War Crimes Act, and the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment ("CAT") prohibit torture and the cruel, inhuman, and degrading treatment of detainees held under US custody.²⁸³ Third, SJR 19 "requests" all relevant California agencies to notify their health professional licensees that they may be subject to prosecution if they participate "in coercive or 'enhanced' interrogation, torture, as defined by CAT, or other forms of cruel, inhuman, or degrading treatment or punishment. . . ."²⁸⁴ Fourth, SJR 19 "requests" that all California licensed health professions report their observations to the appropriate authorities if they "have reason to believe that interrogations are coercive or 'enhanced' or involve torture or cruel, inhuman, or degrading treatment or punishment. . . ."²⁸⁵ Fifth, SJR 19 "requests" the DoD and the CIA to prevent all California-licensed health professionals from taking part in interrogation.²⁸⁶ Lastly, SJR 19 states "[t]hat no law, regulation, order, or exceptional circumstance, whether induced by state of war or threat of war . . . may be

²⁸¹ S.J. Res. 19, 2007-2008 Reg. Sess. (Cal. 2008).

²⁸² *Id.*

²⁸³ *Id.*

²⁸⁴ *Id.*

²⁸⁵ *Id.*

²⁸⁶ *Id.*

invoked as justification for torture or cruel, inhuman, or degrading treatment or punishment. . . ."²⁸⁷

Through these six provisions, the California legislature has made it explicitly clear that it vociferously supports the AMA's ban on physician participation in interrogation. However, an important issue is whether other decision makers, such as the California agencies that issue licenses to health professionals, the DoD, the CIA, or the licensed-health professionals themselves are legally required to comply with SJR 19. Since SJR 19 is only a resolution, it does not operate with the same force of law as a statute. In fact, California law defines "[j]oint [r]esolution" as "[a] resolution expressing the Legislature's opinion about a matter within the jurisdiction of the federal government, which is forwarded to Congress for its information."²⁸⁸ Moreover, a joint resolution in California "[r]equires the approval of both [the] Assembly and Senate, but does not require [the] signature of the Governor."²⁸⁹ Since a joint resolution lacks the essential element of executive approval, it does not rise to the level of law.²⁹⁰

Furthermore, the California Constitution provides that "[t]he Legislature may make no law except by statute and may enact no statute except by bill."²⁹¹ Regarding resolutions and their legal effect, the California Supreme Court has held that:

A mere resolution . . . is not a competent method of expressing the legislative will, where that expression is to have the force of law, and bind others than the members of the house or houses adopting it. The fact that it may have been intended to subserve such purpose can make no difference. The requirements of the constitution are not met by that method of legislation.²⁹²

Thus, while SJR 19 expressly prohibits California physicians from participating in interrogations, it is not legally binding simply because SJR 19 is not a statute. Consequently, if enacting either of the first two legislative measures mentioned above is politically feasible, then those measures should be implemented instead of a resolution.

²⁸⁷ S.J. Res. 19, 2007-2008 Reg. Sess. (Cal. 2008).

²⁸⁸ LEGISLATIVE COUNSEL, STATE OF CAL., A GUIDE FOR ACCESSING CALIFORNIA LEGISLATIVE INFORMATION ON THE INTERNET (2009), http://www.leginfo.ca.gov/guide.html#Appendix_A.

²⁸⁹ *Id.*

²⁹⁰ See *Mullan v. State*, 114 Cal. 578, 584 (1896).

²⁹¹ CAL. CONST. art. IV, § 8(b).

²⁹² *Mullan*, 114 Cal. at 584.

However, SJR 19 is not entirely ineffective. The federal government may choose to comply with the California legislature's request to remove all California-licensed physicians from interrogation activities. Also, SJR 19 may have the desired effect of inspiring the California medical board to exercise its discretion to enforce Opinion 2.068. Furthermore, SJR 19 may deter California licensed physicians from taking part in interrogations in order to avoid the shame and disgrace that is associated with such conduct. Thus, a resolution that vociferously condemns the practice of physician participation in interrogation is certainly a better response from a state legislature than inaction or indifference to the issue.

IV. RECOMMENDATIONS

The AMA's and APA's recent efforts to enact new ethical guidelines are not sufficient to prevent physicians from conducting or supervising abusive interrogations of detainees held in Guantanamo. If the Code of Ethics alone could deter unprofessional medical conduct, then the physicians who helped craft the 2006 DoD Instructions would have ended the practice of using physicians to monitor interrogations. Since the DoD has shown an unwillingness to comply with AMA Opinion 2.068, state legislatures must fulfill the responsibility of enforcing medical ethics' ban on physician participation in interrogation.

The best option to enforce AMA Opinion 2.068 is to enact a statute that explicitly prohibits physicians from participating in interrogation. Lawmakers should prefer this option over a statute that authorizes the state medical board to discipline physicians for conduct that violates the AMA's Code of Ethics simply because some judges, such as the dissenting judge in *Pons*, hesitate to strip defendant-physicians of their ability to practice their profession for conduct that does not explicitly violate the law.²⁹³ A statute that expressly prohibits the practice of physician participation in interrogation resolves all due process concerns that a potential offender may raise in a license challenge case by removing any doubt as to whether such practice is legal. As mentioned before, Kentucky has embraced this approach in resolving the controversy surrounding physician participation in executions.

Kentucky, like Ohio, has a statute that authorizes its medical board to discipline a physician for violating any provision of the

²⁹³ *Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748, 754 (Ohio 1993) (Pfeifer, J., dissenting).

AMA's Code of Ethics. However, unlike Ohio, Kentucky has passed a statute that expressly forbids the practice of physician participation in executions,²⁹⁴ even though the AMA Code of Ethics already prohibits such practice in Opinion 2.06. Thus, a statute that unequivocally proscribes physicians from participating in interrogations may even be necessary in states that have already incorporated the AMA's Code of Ethics into their licensing statute in order to remove any doubts as to whether such practice is prohibited.

If state legislators are unable to pass legislation that prohibits physician participation in interrogations, then they should adopt a statute that authorizes their medical board to discipline licensees for violating any provision of the AMA Code of Ethics. Under this type of medical licensing statute, a state medical board will have the authority to investigate and discipline its licensees for participating in interrogations, since the AMA has unequivocally banned such conduct in Opinion 2.068. However, a statute that incorporates the AMA Code of Ethics into its licensing statute is only effective if the state medical board decides to enforce Opinion 2.068. Even if a state has incorporated the AMA Code of Ethics into its medical license statute, the state medical board can still choose to exercise its discretion to not investigate and discipline physicians that violate Opinion 2.068. Therefore, lawmakers should prefer a statute that explicitly prohibits physician participation in execution because such a statute would help overcome a state medical board's reluctance to enforce Opinion 2.068.

The third and least appealing legislative option to address the practice of physician participation in interrogation is to enact a resolution that publicly condemns such practice. The California state legislature has implemented this measure by enacting SJR 19. While SJR 19 does not function with the same force of law as a statute does under California law, it nonetheless is better than inaction or indifference to the matter. By explicitly prohibiting licensed health professions from taking part in interrogation and by warning them that they may be prosecuted should they do so, SJR 19 delivers a strong message to all licensed California physicians that they should keep out of the interrogation room. Even though SJR 19 is not as legally binding as a statute, it may embolden other agencies, such as the state medical board, to be more proactive in investigating and disciplining California physicians that have participated in interrogation activities. Moreover, the strong condemnation expressed by the state legislature

²⁹⁴ KY. REV. STAT. ANN. § 431.220(3) (West 2008).

may be sufficient enough to deter California licensed health professionals from participating in interrogations.

The enactment of SJR 19 reveals the political difficulties involved in passing a legislative measure that addresses the problem of physician participation in interrogation. In both the California Senate and Assembly, the vote for SJR 19 was extremely partisan. The California Senate adopted SJR 19 by a 22 to 11 vote.²⁹⁵ The 22 state senators that voted for SJR 19 were all Democrats, and the 11 state senators that voted against the resolution were all Republicans.²⁹⁶ In the California State Assembly, SJR 19 was enacted by a 45 to 31 vote.²⁹⁷ All 45 assembly members that voted for the resolution were Democrats, and the 31 assembly members that voted against SJR 19 were Republicans.²⁹⁸ The overtly partisan vote for SJR 19 reveals that the political environment in some states may not allow lawmakers to enact a statute that either explicitly or implicitly prohibits the practice of physician participation in interrogation. Therefore, a resolution, rather than a statute, may be the most politically feasible option to end the practice of physician participation in interrogation in such states. While a resolution may not operate with the same force of law as a statute, a resolution by the state legislature that condemns the use of physicians to facilitate interrogations is certainly better than remaining silent.

V. CONCLUSION

The AMA's Council on Ethical and Judicial Affairs provides that if physicians, in any circumstance, engage in activities that are physically or mentally coercive, then the entire medical profession is tainted.²⁹⁹ Thus, perhaps one of the greatest threats to the integrity of the medical profession is the Pentagon's continued use of BSCT psychiatrists to direct and supervise interrogations. No professional code of medical or psychiatric ethics agrees with the Pentagon's asser-

²⁹⁵ Ryan Parker, *Important News: SJR 19 Was Passed*, SURVIVORS INT'L (Survivors Int'l, S.F., Cal.), Apr. 25, 2008, <http://www.survivorsintl.org/article.php?story=20080425161233803&mode=print>.

²⁹⁶ *Id.*

²⁹⁷ SJR 19 Senate Joint Resolution, Vote Information, http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0001-0050/sjr_19_vote_20080812_0435PM_asm_floor.html (last visited Jan. 31, 2009).

²⁹⁸ *See id.*; *see also* Cal. State Assembly, California Roster 2008, http://www.sos.ca.gov/admin/ca-roster/2008/pdf/01f_ca_assembly.pdf. *See also*, *California State Assembly Roster*, http://www.sos.ca.gov/admin/ca-roster/2008/pdf/01f_ca_assembly.pdf.

²⁹⁹ CEJA REP. 10-A-06, *supra* note 148, at 7.

tion that BSCT psychiatrists may participate in coercive and psychological interrogations because no physician-patient treatment relationship exists between the BSCT psychiatrist and the detainee.³⁰⁰ In fact, both the AMA and APA enacted new ethical guidelines that strictly forbid physician and psychiatrist participation in interrogations. However, to effectively enforce AMA Opinion 2.068 and support a state medical board's prerogative to investigate and discipline its licensees for participating in interrogations, state lawmakers must enact one of the three legislative measures mentioned above.

The medical profession's relationship with the public is based on trust.³⁰¹ Society expects physicians to use their powers to heal. Even in times of war, the public expects physicians to use their skills and knowledge for therapeutic purposes only.³⁰² Thus, both the AMA and the APA must work hard to push lawmakers to pass one of the three statutory measures recommended in this note so that the integrity of the medical profession remains untarnished.

³⁰⁰ See Emily A. Keram, *Will Medical Ethics Be a Casualty of the War on Terror?*, 34 J. AM. ACAD. PSYCHIATRY & L. 6, 8 (2006).

³⁰¹ CEJA REP. 10-A-06, *supra* note 148, at 6.

³⁰² *Id.*