

# REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*\*†

CEJA Report 10-A-06

Subject: Physician Participation in Interrogation (Res. 1, I-05)

Presented by: Priscilla Ray, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(Joseph H. Reichman, MD, Chair)

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## 1 INTRODUCTION

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3 At the 2005 Interim Meeting, the House of Delegates adopted amended Resolution 1, I-05,  
4 “Physician Participation in the Interrogation of Prisoners and Detainees,” which directed the  
5 Council on Ethical and Judicial Affairs to delineate the boundaries of ethical practice with respect  
6 to physicians’ participation in the interrogation of prisoners and detainees.

7

8 The resolution arose from concerns in recent years regarding the role of physicians in interrogation  
9 practices, including involvement as Behavioral Science Consultants to advise interrogators.<sup>1, 2, 3, 4, 5</sup>

10 This report focuses on the role of physicians in the interrogation process in the specific contexts of  
11 domestic law enforcement and military or national security intelligence gathering.

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\* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

† NOTE: The Council on Ethical and Judicial Affairs presents CEJA Report 10, A-06, “Physician Participation in Interrogation,” as a Late Report, acknowledging that this limits the time during which Delegates can review the full report. However, the Council sought input from a large number of interested organizations and individuals by sharing an early draft of the Report. Because this topic has been the focus of considerable ongoing public debate, the Council believes it is in the best interest of the AMA and particularly of colleagues currently serving in the military to present the Report to the House at this time, as a Late Report.

The Council considers that the time required to process the wide range of comments that were solicited, which resulted in the delay in submitting this Report to the House, was time well spent. After thorough reflection and deliberation on the broad spectrum of sharply conflicting opinions of reviewers, the Report now strongly and clearly describes the ethics of physicians as they relate to interrogations. The Council members are deeply grateful to all those who participated in this process.

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ELEMENTS OF THE DEBATE

*Interrogation: Definition and Description*

For the purpose of this Report, we define a “detainee” as a criminal suspect, prisoner of war, or any other individual who is detained and is potentially subject to interrogation. An individual who undergoes interrogation is referred to as an “interrogatee.” Most broadly, interrogation has been defined as formal and systematic questioning.<sup>6</sup> However, in this Report, we define interrogation more narrowly, as questioning related to law enforcement or to military and national security intelligence gathering designed to prevent the occurrence or recurrence of harm or danger to individuals, the public, or national security. The interrogation aims to elicit information from a detainee that is useful to the purposes of the interrogators. Interrogations are also distinct from questioning used to assess the medical condition of an individual or to determine mental status. Accordingly, forensic medicine practices that include assessing competence to stand trial or criminal responsibility, and pre-sentencing evaluations are excluded from this report. Appropriate interrogations should be carefully distinguished from those coupled with coercive acts that are intended to intimidate and that may cause harm through physical injury or mental suffering. In general, this Report does not address participation of physicians in developing strategies to deal with individuals who are not in detention, such as negotiations with hostage takers and profiling of criminal suspects. From the physician’s perspective, an interrogation is distinct from questioning conducted for purposes of making a diagnosis, assessing physical capacity, or determining mental capacity related to legal status.

The military and related government agencies refer to interrogations, debriefings and tactical questioning as means to gain intelligence from captured or detained personnel.<sup>7</sup> The Army Field Manual further defines interrogation as “the process of questioning a source to obtain the maximum amount of usable information. The goal is to obtain reliable information in a lawful manner, in a minimum amount of time, and to satisfy intelligence requirements of any echelon of command.”<sup>8</sup>

*Interrogation Techniques*

The Army Field Manual provides detailed guidance on interrogations and describes methods to establish rapport with or exert control over a detainee. Specific psychological strategies that rely primarily on incentives, emotions, fear, pride and ego are generally considered acceptable, although it is recognized that approaches that rely on fear presents “the greatest potential to violate the law of war.”<sup>8</sup>

Significant concerns regarding interrogations arise from the risk of abuse. Domestic and international law prohibit the use of coercive interrogations that might involve the application of mild to severe physical or mental force.<sup>9, 10</sup>

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1 In criminal law, coercion or undue intimidation violates the rights of individuals being interrogated.  
2 Moreover, such abuses can undermine the veracity of information derived from an interrogation  
3 and can jeopardize subsequent legal proceedings intended to establish true facts about a crime.<sup>11</sup>  
4 Therefore, safeguards of due process have been placed on interrogatory powers in order to protect  
5 against coercive techniques.<sup>12</sup> Actions by law enforcement agents may be legally reviewed, and  
6 information gathered by coercive means may be rejected from court proceedings.

7  
8 Policies that traditionally have governed military or national security interrogations expressly  
9 prohibit “acts of violence or intimidation, including physical or mental torture, threats, insults, or  
10 exposure to inhumane treatment as a means of or aid to interrogations.”<sup>8</sup> Thus, there are limits to  
11 manipulating or exploiting an individual’s physical and mental status to elicit information. These  
12 limits are grounded in the Geneva Conventions, which in part state: “No physical or mental  
13 torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them  
14 information of any kind whatever. Prisoners of war who refuse to answer may not be threatened,  
15 insulted, or exposed to unpleasant or disadvantageous treatment of any kind.”<sup>13</sup>

16  
17 Similar limitations are found in the United Nations’ Convention against Torture and Other Cruel,  
18 Inhuman or Degrading Treatment or Punishment, which prohibits “any act by which severe pain or  
19 suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as  
20 obtaining from him or a third person information or a confession [...]”<sup>14</sup> Accordingly,  
21 determining the point at which any interrogation becomes coercive is of great significance. While  
22 physicians can provide insights into the physically and mentally harmful effects of interrogation  
23 practices, they alone cannot authoritatively define the tipping point between appropriate and  
24 inappropriate interrogation practices.

## 25 26 PHYSICIANS AND THE INTERROGATION PROCESS

27  
28 Some physicians, most often psychiatrists, may engage in activities that are closely linked to  
29 interrogations. For example, in the course of criminal proceedings, physicians may be asked to  
30 assess the mental condition of an individual who is to be interrogated, either to prevent an  
31 interrogation that would be harmful to the individual’s health<sup>15</sup> or to identify mental impairments  
32 that could negate the value of disclosed information. Other assessments may include the  
33 determination of an individual’s mental competency to stand trial, or the availability of the insanity  
34 defense. Physicians sometimes provide consultations to law enforcement officers regarding fruitful  
35 approaches to interacting with suspects, for example, in criminal profiling and hostage  
36 negotiations. Specific guidelines for ethical behavior of psychiatrists serving as forensic  
37 consultants have been developed by the American Academy of Psychiatry and the Law.<sup>16</sup> In most  
38 of these examples, a physician’s training and skills help determine whether a mental impairment  
39 exists that would have some bearing on legal proceedings.<sup>17</sup> The physician’s primary aim is not to  
40 persuade the individual to reveal incriminating information, although such information may be  
41 revealed as a secondary consequence of questioning. Similarly, the determination of physical or  
42 mental impairments may bear on administrative proceedings, such as eligibility to receive funds or  
43 services, but these assessments are also distinct from interrogations as defined in this report.

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1 *General Arguments for and against Physician Involvement in the Interrogation Process*

2  
3 Without being coercive, interrogations rely on psychological manipulation producing stress,  
4 anxiety, or other forms of discomfort. The physical or mental impact of these practices may justify  
5 a role for physicians in interrogations.<sup>18</sup> Physicians could enhance the likelihood of successful  
6 interrogation by identifying useful strategies, providing information that may be useful during  
7 questioning, or putting interrogatees at ease. Furthermore, physicians could protect interrogatees  
8 if, by monitoring, they prevent coercive interrogations. However, physician involvement could  
9 also lead to the belief on the part of interrogators that they can escalate the use of force until the  
10 physician intervenes.<sup>19, 20</sup>

11  
12 From the perspective of ethical responsibilities, all physicians who engage in activities that rely on  
13 their medical knowledge and skills must uphold the principles of beneficence and non-maleficence  
14 and refrain from participating in situations that may cause harm without corresponding benefit.  
15 They must also respect patient autonomy and must protect the confidentiality of personal  
16 information, unless breaching them is clearly justified by tenets of medical ethics. Some benefits  
17 of interrogation may accrue to the detainee or to other individuals (e.g., exoneration from a crime),  
18 but the intention of interrogation is not to benefit the detainee; rather, it is to protect the public or  
19 other individuals from harm due to domestic or foreign threats. These are laudable goals, but it is  
20 not clear that the medical knowledge and skills of physicians should be used for purposes unrelated  
21 to medicine or health to further the interests of groups against those of individuals, such as  
22 detainees. Striking a balance between obligations to individuals and obligations to society may be  
23 difficult, but when the obligations seem approximately equal, the weight should shift toward  
24 individuals.

25  
26 The principles of respect for autonomy, beneficence, non-maleficence and protection of  
27 confidentiality are at risk of being violated during interrogations. Therefore, it is essential that the  
28 ethical role of physicians in interrogations be clearly defined.

29  
30 Physicians' Dual Loyalties

31  
32 In the clinical setting, physicians' obligations are first to their patients. However, in many other  
33 settings, physicians confront dual loyalties, which place the medical interests of the individuals  
34 with whom they interact in tension or conflict with those of third parties to whom the physicians  
35 are accountable. For example, when a physician assesses an employee's health for an employer,  
36 the physician has certain ethical responsibilities to the examinee as well as contractual  
37 responsibilities to the employer. However, the AMA's Code of Medical Ethics makes clear that  
38 the physician must not fulfill responsibilities to the employer in a manner that is detrimental to the  
39 employee's medical condition,<sup>21</sup> nor disclose medical information without the consent of the  
40 employee.<sup>22</sup>

41  
42 Physicians who provide medical care in detention or correctional facilities face divided loyalties: to  
43 the medical interests of the detainees and respect for their (legally limited) autonomy, and to the  
44 correctional facility's control over detainees and need for information. Concerns are heightened

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1 when interrogations are conducted.<sup>23</sup> Some, including military and government officials,<sup>24, 25</sup> have  
2 suggested that physicians who do not provide medical care to interrogatees are not bound by  
3 physicians' ethical obligations to patients because they act outside of the patient-physician  
4 relationship. However, various Opinions in the AMA's Code of Medical Ethics suggest that  
5 physician interactions under the authority of third parties are governed by the same ethical  
6 principles as interactions involving patients.<sup>26</sup> Physicians must apply medical knowledge and skills  
7 within the profession's ethical standards, which are distinct from and often more stringent than  
8 those of the law.

9  
10 Confidentiality of Detainee Information

11  
12 Confidentiality is of particular concern when physicians provide medical care in settings where  
13 interrogations might occur. Interrogators might believe that interrogation will be more effective if  
14 informed by medical information, and might pressure physicians to share information obtained in  
15 the course of a patient-physician encounter. Opinion E-5.05, "Confidentiality," places great  
16 emphasis on the confidentiality of personal information that patients provide to physicians. The  
17 Opinion recognizes limited circumstances in which breaching confidentiality may be justifiable, for  
18 example, disclosures related to foreseeable and preventable harm to identifiable third parties. It is  
19 otherwise unethical to divulge personal information without the authorization of the patient. When  
20 medical records belong to the detention facility, physicians should warn detainee-patients that the  
21 information they provide for the medical record is accessible to facility authorities.

22  
23 Moreover, in the context of physician employment by third parties, information should not be  
24 communicated to the third party without prior notification of the interrogatee that any information  
25 they provide may be passed on to a third party.<sup>22</sup> The fact that interrogation may be legally  
26 mandated or protected does not ethically justify communication of confidential information by a  
27 physician without notification and the individual's approval.

28  
29 *Specific Roles*

30  
31 To assess the ethics of physician involvement in interrogations, it is useful to distinguish various  
32 activities in which physicians may be involved.

33  
34 Physicians are ethically justified in acting to prevent harm to individuals. In this regard, the  
35 suggestion that physicians should observe or monitor interrogations to prevent harm requires  
36 careful scrutiny. As defined in this report, appropriate interrogations present no reason for medical  
37 monitoring, because interrogators ought to abstain from coercive questioning. Physicians can  
38 determine that harm has been inflicted but, in many instances, cannot predict whether an  
39 interrogation practice will or will not cause harm.

40  
41 Physicians may be asked to determine the overall medical fitness of detainees or their mental  
42 capacity, and to use their knowledge and skills to assess the health of detainees; questioning to  
43 elicit medical information of this kind is distinct from interrogations and is appropriate. The  
44 presence of a physician at an interrogation, particularly an appropriately trained psychiatrist, may

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1 actually benefit the interrogatee because of the belief held by many psychiatrists that kind and  
2 compassionate treatment of detainees can establish trust that may result in eliciting more useful  
3 information. However, physicians who provide medical care to detainees should not be involved in  
4 decisions whether or not to interrogate because such decisions are unrelated to medicine or the  
5 health interests of an individual.

6  
7 A physician may be requested or required to treat a detainee to restore capacity to undergo  
8 interrogation. If there is no reason to believe that the interrogation was coercive, there is no ethical  
9 problem. As with all patients, physicians should not treat detainees without their consent (see  
10 Opinion E-8.08, "Informed Consent"). Moreover, in obtaining consent for treatment, implications  
11 of restoring health, including disclosure that the patient may be interrogated or an interrogation  
12 may be resumed, must be disclosed. If a physician identifies physical or psychological injuries that  
13 are likely to have occurred during an interrogation, the physician must report such suspected or  
14 known abusive practices to appropriate authorities.

15  
16 Development of interrogation strategies constitutes indirect involvement in interrogation. Specific  
17 guidance by a physician regarding a particular detainee based on medical information that he or she  
18 originally obtained for medical purposes constitutes an unacceptable breach of confidentiality.  
19 Moreover, it is unethical for a physician to provide assistance in a coercive activity, because such  
20 activities fundamentally undermine the respect for individual rights that is basic to medical ethics.  
21 The question of whether it is ethically appropriate for physicians to participate in the development  
22 of interrogation strategies may be addressed by balancing obligations to society against those to  
23 individuals, as noted in the above section on "General Arguments". Direct participation in an  
24 individual interrogation is not justified, because physicians in the role of interrogators undermines  
25 their role as healers and thereby erodes trust in both themselves as caregivers and in the medical  
26 profession, and non-medical personnel can be trained to be expert interrogators. But a physician  
27 may help to develop general guidelines or strategies, as long as they are not coercive and are  
28 neither intended nor likely to cause harm, and as long as the physician's role is strictly that of  
29 consultant, not as caregiver.

30  
31 Any physician involved with individuals who will undergo or have undergone interrogations  
32 should have current knowledge of known harms of interrogation techniques. For example, some  
33 research has shown that isolation is a harmful interrogation tactic.<sup>27</sup> Once an interrogation strategy  
34 is shown to produce significant harm, whether immediate or long term, it should be reported to  
35 appropriate authorities so that its use can be prohibited. If responsible authorities do not prohibit a  
36 clearly harmful interrogation strategy, physicians are ethically obligated to report the offenses to  
37 independent authorities that have the power to investigate or adjudicate such allegations.

#### 38 39 CONCLUSION

40  
41 The practice of medicine is based on trust. Physicians are expected to care for patients without  
42 regard to medically irrelevant personal characteristics. This fundamental tenet of medical ethics  
43 underlies the doctrine of medical neutrality, whereby in times of war physicians are expected to  
44 treat casualties within triage protocols, irrespective of patients' military or civilian status.

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1  
2 Any physician involvement with detainees who may undergo interrogation must be guided by the  
3 same ethical precepts that govern the provision of medical care, never using medical skills and  
4 knowledge to intentionally or knowingly harm a patient without corresponding benefit, and  
5 respecting patient autonomy by obtaining consent to the provision of care and protecting  
6 confidential information. Physicians have long dealt with problems of dual loyalties in forensic  
7 roles and as employees of government and business. The same ethical considerations that guide  
8 physicians under those circumstances also guide them in matters related to interrogation.  
9 Physicians in all circumstances must never be involved in activities that are physically or mentally  
10 coercive. If physicians engage in such activities, the whole profession is tainted.

11  
12 Questions about the ethical propriety of physicians participating in interrogations and in the  
13 development of interrogation strategies may be addressed by balancing obligations to society with  
14 obligations to individuals. Direct participation in interrogation of an individual detainee is not  
15 justified, because non-medical personnel can be trained to be expert interrogators, minimizing the  
16 need for presence of a physician. But, out of an obligation to aid in protecting third parties and the  
17 public, a physician may help to develop general guidelines or strategies for interrogations, as long  
18 as the strategies are not coercive, and as long as the physician's role is strictly that of consultant,  
19 not as caregiver.

## 20 21 RECOMMENDATIONS

22  
23 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the  
24 remainder of this report be filed:

25  
26 For this report, we define interrogation as questioning related to law enforcement or to military  
27 and national security intelligence gathering, designed to prevent harm or danger to individuals,  
28 the public, or national security. Interrogations are distinct from questioning used by physicians  
29 to assess the physical or mental condition of an individual. To be appropriate, interrogations  
30 must avoid the use of coercion—that is, threatening or causing harm through physical injury or  
31 mental suffering. We define a “detainee” as a criminal suspect, prisoner of war, or any other  
32 individual who is being held involuntarily by legitimate authorities.

33  
34 Physicians who engage in any activity that relies on their medical knowledge and skills must  
35 continue to uphold ethical principles. Questions about the propriety of physician participation  
36 in interrogations and in the development of interrogation strategies may be addressed by  
37 balancing obligations to individuals with obligations to protect third parties and the public.  
38 The further removed the physician is from direct involvement with a detainee, the more  
39 justifiable is a role serving the public interest. Applying this general approach, physician  
40 involvement with interrogations during law enforcement or intelligence gathering should be  
41 guided by the following:

42  
43 (1) Physicians may perform physical and mental assessments of detainees to determine the  
44 need for and to provide medical care. When so doing, physicians must disclose to the

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- 1 detainee the extent to which others have access to information included in medical records.  
2 Treatment must never be conditional on a patient's participation in an interrogation.  
3  
4 (2) Physicians must neither conduct nor directly participate in an interrogation, because a  
5 role as physician-interrogator undermines the physician's role as healer and thereby erodes  
6 trust in the individual physician-interrogator and in the medical profession.  
7  
8 (3) Physicians must not monitor interrogations with the intention of intervening in the  
9 process, because this constitutes direct participation in interrogation.  
10  
11 (4) Physicians may participate in developing effective interrogation strategies for general  
12 training purposes. These strategies must not threaten or cause physical injury or mental  
13 suffering and must be humane and respect the rights of individuals.  
14  
15 (5) When physicians have reason to believe that interrogations are coercive, they must  
16 report their observations to the appropriate authorities. If authorities are aware of coercive  
17 interrogations but have not intervened, physicians are ethically obligated to report the  
18 offenses to independent authorities that have the power to investigate or adjudicate such  
19 allegations. (New HOD/CEJA Policy)

Fiscal Note: Staff costs estimated at less than \$500 to implement.

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- <sup>11</sup> American courts recognize that confessions elicited by physical intimidation are involuntary and may not be admitted against the confessor at trial. Additionally, under certain circumstances threats, deception, and trickery may render a confession involuntary and inadmissible. 29 Am. Jur. 2d Evidence § 731.
- <sup>12</sup> The Fifth and Fourteenth Amendments to the Constitution protect individuals against involuntary self-incriminating statements. *Dickerson v. United States*, 530 U.S. 428 (2000); *Miranda v. Arizona*, 384 U.S. 436 (1966).
- <sup>13</sup> Geneva Convention III, Article 17
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<sup>20</sup> See Milgram, S, 1963. Behavioral study of obedience. *Journal of Abnormal and Social Psychology*, which suggests that subjects are more likely to inflict greater harm if under the supervision of an authoritative supervisor.

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