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Standardizing psycho-medical torture during the War on Terror: Why it happened, how it happened, and why it didn't work

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ABSTRACT

After 9/11/2001 the United States launched a global War on Terror. As part of this War, terrorism suspects were detained by the U.S. military and by the C.I.A. It is now widely recognized that the United States tortured a number of these detainees in the context of its 'enhanced interrogation' programme. This article examines how and why U.S. organizations developed standards that allowed healthcare professionals to become involved in torture; why the standards developed by U.S. security institutions failed to control the actions of enhanced interrogation personnel on the ground; and what the role of standards were in stopping the enhanced interrogation initiative. The article concludes by discussing the general lessons that the enhanced interrogation programme has for social science research on standards, namely that individuals can experience ambivalence when caught between competing organizational and professional standards and that it might be inherently difficult to successfully enact certain protocols when these relate to deviant or destructive acts.

1. Introduction

After 9/11/2001 the United States launched a global War on Terror. Suspects were captured by the U.S. military and by the C.I.A. and detained at various acknowledged and black sites across the world. It is now widely recognized that the United States tortured a number of detainees in its custody in the context of its 'enhanced interrogation' programme (IMAP/OSF, 2013; SSIR, 2014).

This torture had a number of features. One was a strong reliance on healthcare professionals, who supported, designed and carried out enhanced interrogation. A second feature was the emphasis placed by the programme on clean (Rejali, 2007) violence. A third was the role played by standards, protocols and guidelines in the torture programme.

To date, no study has fully considered the role that standards played in enhanced interrogation. This is an important absence because standards were key to the entire initiative. They were invoked throughout all its stages, from its development through to its termination. One of the key documents that initially justified the programme's violent tactics, for example, was called the "Standards of Conduct for Interrogation 18 USC 2340-2340A" (Department of Justice, 2002). Without the standards developed in this and related documents, the enhanced interrogation programme could not have been created, let alone operationalized.

Standards were also significant because they were responsible for drawing health professionals into torture. Research on standards suggests that, because of their ability to systematise technical information, scientific experts are often called upon when standards are being formulated (Jordan and Lynch, 1998). Health professionals became involved in the enhanced interrogation programme out of a perceived need to regulate interrogation practices and thereby protect detainees from harm. This shows that health professionals can become drawn into serious medical deviance through a mixture of moral and bureaucratic imperatives bound up in standards.

Finally, a third reason to consider the role played by standards in the enhanced interrogation programme is because the programme highlights that certain activities cannot be standardized. Although the point that health professionals often find it difficult to standardize their activities has been previously noted (Timmermans, 2005), it is worth emphasising it again in this context given that the programme's authorization was based on a belief on the part of policy and operational architects that brutal interrogation tactics could be standardized.

This article has two purposes. The first is to consider the overall role played by standards in the enhanced interrogation programme. The second is to consider the wider lessons that the case study of

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enhanced interrogation has for the more general field of the sociology of standards. The first section of this article therefore considers recent sociological research on standards. This is followed by sections on the creation of enhanced interrogation standards, why health professionals became involved in standard creation, how torture standards played out in practice, and the role played by standards in stopping the programme. The discussion considers the wider lessons that the enhanced interrogation programme offers.

2. Methods

This article is based on an analysis of data extracted from key government (e.g. SSIR, 2014) and health professional reports (e.g. IMAP/OSF, 2013), and government protocols that the enhanced interrogation programme used (Department of Justice, 2002, 2005). The article also draws upon news media articles from sources of record (e.g. the New York Times, the New Yorker) that discuss the standards used by the programme. Information from all these sources was extracted and thematically organised.

This article has two limitations. One is the fact that it is mainly, though not exclusively, based on an assessment of secondary sources. Even a central document such as the SSIR report is a 500 page summary of a much longer (close to 6000 pages) report, which is itself a summary of a vast range of documentation. That longer report has not been released. So while this article is comprehensive, much of its information is not based on primary sources, which remain classified and/or redacted. At the time that this article was written (late 2016), for example, Physicians for Human Rights noted that the CIA had “redacted nearly all details concerning the CIA's Office of Medical Services” (Physicians for Human Rights, 2016). For the purposes of this article, however, sufficient information is publicly available to provide an overview of the role that standards played in the programme.

The second limitation is that individuals who are critical of the enhanced interrogation programme have written most of the secondary sources. This article has taken the position that these individuals' reports not only provide information about the enhanced interrogation programme, they are also examples of the ‘anti-enhanced interrogation standard’ in action.

3. Sociology of standards

The past decade have seen significant research interest in standards, and the impacts that standards have for organizations and individuals. A standard, broadly speaking, is a convention or requirement (Timmermans and Epstein, 2010), usually outlined in a formal document, that describes the uniform methods and processes that need to be undertaken if the standard is to be met. Standards fit somewhere between laws and norms in their ability to direct action, and have, as such, been called ‘soft regulations’ (Timmermans and Epstein, 2010).

Standards have a number of characteristics. Despite their ubiquity, standards tend to be infrastructures that escape notice (Star and Lampland, 2008). They are often developed by professional groups and external (often national and international) bodies. The military is one institution that has always expressed a strong interest in standards and standardization, and most industrialized nations see standardization as central to their national security (Busch, 2010). A standard model of training, for example, is necessary to ensure that military personnel receive the same training and can be relied upon to act in standard ways in high-pressure situations. Even terrorist groups develop detailed standards to control their activities (Star and Lampland, 2008).

Standards are often used to regulate practice, that is to create uniformity across time and space through the creation of agreed-upon rules and ways of acting (Bowker and Star, 1999; Timmermans and Epstein, 2010). For instance when an individual boards a plane one of the first things that they notice is that airline personnel act the same way and engage in the same activities each time, such as cross-checking the door and preparing for departure. For safety purposes their activities are fully controlled; there is little variability from situation to situation. Medicine and its allied professions also develop standards to improve the effectiveness, quality and safety of care, and to decrease variations in care.

Standards often fail in practice. A new standard enters a world that is populated by practices, people and other standards that might not be compatible with or controllable by the new standard. People may refuse to comply with or follow the standard (Star and Lampland, 2008); activist groups often resist standards, or seek to alter standards to meet their particular aims (Whooley, 2010). Whooley (2010) for instance notes that while psychiatrists theoretically need to provide patients with a defined type of diagnosis from DSM, in practice they often develop their own ‘deviant’ diagnoses that do not match those outlined in the guidelines. In general, a notable feature of modern medicine is how difficult it is to get healthcare professionals to adopt and follow standards; compliance rates may low (McDonald et al., 2005; Timmermans, 2005) for reasons such as lack of awareness, lack of familiarity and lack of agreement with the standard (Busch, 2010; Cabanna et al., 1999) and a feeling that standardization is often linked directly to dehumanization of care (Timmermans and Almeling, 2009).

The outcome is that very few standards work completely as expected (Timmermans and Almeling, 2009). Often rather than standardizing practice, standards transform practice in unpredictable ways (Star, 1995; Timmermans and Almeling, 2009). To keep the standard working effectively, support armies of technicians may be needed (Busch, 2000). In medicine, standards may be further maintained through the development of evidence-based medicine and systematic reviews, and also through the use of clinical guidelines (Timmermans, 2005).

Standards have a complicated, mediating role between professions and bureaucracies. Traditionally, professions developed their own standards, which allowed them to delimit their professional territory within the context of countervailing relationships with other groups (Timmermans, 2005). This reflected the ability of professional groups to self-regulate and, largely, to determine their own destinies. Increasingly, however, members of the professions are finding themselves working for powerful state or corporate bureaucracies. These organizations may create their own standards which they can impose upon the profession, or ask it to follow (Timmermans, 2005). The creation of standards in these situations, and how they are used and responded to, therefore reveals important information about the nature of the relationship between the profession and the bureaucracy; and how the conflicts are resolved can say something important about the profession's values and priorities.

4. Medical standards and torture

All healthcare professions produce ethical standards, manifested in guidelines, protocols and principles, that govern their members’ behaviour; regulation of ethical behaviour through codes is in fact one of the defining features of a profession. These standards of conduct outline the behaviours that healthcare professionals should and should not engage in.

For doctors, a foundational ethical standard or principle is ‘do no harm’; another is ‘do good’ (Miles, 2006). Torture and other forms of cruel, inhuman and degrading treatment violate these principles in a number of ways, and consequently the medical profession has