

Statement of Independent Medical Experts
on
“Closing Guantánamo: Ending 20 Years of Injustice”

Before the Senate Judiciary Committee
December 7, 2021

We are pleased to submit this statement for the Committee’s December 7, 2021 hearing: Closing Guantánamo: Ending 20 Years of Injustice. Between us we have spent thousands of hours over the last 15 years evaluating Guantánamo detainees, reviewing their medical records, and otherwise engaging with and/or studying Guantánamo’s medical care system. We submit this statement to provide the Committee with our perspective on the state of medical care at Guantánamo, the urgent concerns the situation presents, and our recommendations for immediate steps necessary to alleviate those concerns.¹

We recommend closing Guantánamo, which is the only way to fully resolve all of our serious concerns. Until that happens, it is the United States’ legal and ethical obligation to mitigate them to the greatest extent possible. Congress created the position of Chief Medical Officer at Guantánamo in the Fiscal Year 2020 National Defense Authorization Act in order to address many of these concerns, but in our experience, they remain. If the problems we have identified are left unaddressed, the United States will remain in breach of its obligations in myriad respects, including failing to comply with its mission to care for individuals in its custody.

Background

More than eight years ago, General John F. Kelly, then SOUTHCOM Commander, testified before the House Armed Services Committee to a “major challenge[.]” facing the United States at Guantánamo: “complex issues related to future medical care of detainees.” He explained that “the medical issues of the aging detainee population are increasing in scope and complexity,” and that, as with any elderly person, “aging detainees could require specialized treatment for issues such as heart attack, stroke, kidney failure, or even cancer.” Guantánamo did not have the “specialists and equipment” necessary for that level of care, he warned.²

Indeed, for years now a variety of detainees’ medical needs – which in many cases arise out of or are exacerbated by their torture and prolonged indefinite detention – have outstripped Guantánamo’s medical care capabilities. This limitation, coupled with the current statutory ban on detainee transfers to the United States, has led to repeated and ongoing violations of the United States’ legal obligation to provide Guantánamo detainees adequate medical care. To the extent there was any dispute in the past about the scope of that obligation, Congress resolved it through the Fiscal Year 2020 National Defense Authorization Act, which requires that detainees

¹ Each of us independent medical experts is writing in our individual capacity, not as a member of any detainees’ legal team.

² Posture Statement of General John F. Kelly, United States Marine Corps Commander, United States Southern Command, Before the 113th Congress House Armed Services Committee at 23-24, March 20, 2013, available at http://www.au.af.mil/au/awc/awcgate/usmc/posture_usmc_20mar2013.pdf.

are provided “evaluation and treatment that is accepted by medical experts and reflected in peer-reviewed medical literature as the appropriate medical approach for the relevant condition, symptoms, illness, and/or disease and that is widely used by health care professionals.”³

Guantánamo’s medical care challenges are going to worsen with time; as the men continue to age, it should be expected that they will increasingly present with medical needs that cannot be managed at Guantánamo, such as strokes, severe heart disease, kidney failure, and myriad significant mental health conditions—including suicidality (which is already an issue for multiple detainees).

Below we describe the most serious deficiencies that we have long experienced and/or observed with respect to medical care at Guantánamo. We note that a recent Department of Defense (DOD) response⁴ to a congressional oversight letter on this issue⁵ corroborates several of our concerns.

Guantánamo lacks the necessary medical-care capabilities to appropriately address the medical issues that detainees are facing

Guantánamo was designed for short term detention operations and its healthcare infrastructure was built accordingly. It was never intended, and was not resourced, to provide the type of sophisticated medical care that is increasingly required. Medical needs detainees have presented or are now presenting, and that Guantánamo cannot adequately manage – due to lack of equipment, diagnostic capabilities, and/or expertise – include, but are not limited to:

- Any major surgery (spine, cardiothoracic, brain, vascular, cancer surgery (pancreatic, prostate, etc.))
- Any condition that requires the consistent availability of sophisticated diagnostic capabilities (e.g., MRI, PET scan) and access to emergent procedures – such as cardiac catheterization and stroke treatment – that become increasingly important when caring for an aging population
- Chronic suicidality and self-harming behaviors
- Dementia (especially at risk in a population with head injuries)
- Complex post-traumatic stress disorder and similarly significant mental health conditions
- Severe heart disease
- Traumatic brain injury and postconcussion syndrome

³ National Defense Authorization Act for Fiscal Year 2020 § 1046, Public Law 116-92, Dec. 19, 2019, available at <https://www.congress.gov/116/plaws/publ92/PLAW-116publ92.pdf>.

⁴ July 9, 2020 Letter to the Hon. Elizabeth Warren from Matthew P. Donovan, available at https://www.cvt.org/sites/default/files/attachments/u101/downloads/dod_response_to_warren_letter-3_pages.pdf (“DOD response to congressional oversight letter”).

⁵ May 28, 2020 Letter to the Hon. Mark T. Esper from Senators Elizabeth Warren (D-Mass.), Jack Reed (D-R.I.), Patrick Leahy (D-Vt.), Dianne Feinstein (D-Calif.), Dick Durbin (D-Ill.), Edward J. Markey (D-Mass.), Sherrod Brown (D-Ohio), Bernie Sanders (I-Vt.), Tammy Baldwin (D-Wis.), Cory Booker (D-N.J.), Chris Coons (D-Del.), Jeff Merkley (D-Ore.), Ron Wyden (D-Ore.), Ben Cardin (D-Md.), and Tom Carper (D-Del.), available at [https://www.warren.senate.gov/imo/media/doc/2020.05.27%20Letter%20to%20DoD%20re%20Coronavirus%20Mitigation%20at%20Guantanamo%20Bay%20Prison%20Facility%20\(1\).pdf](https://www.warren.senate.gov/imo/media/doc/2020.05.27%20Letter%20to%20DoD%20re%20Coronavirus%20Mitigation%20at%20Guantanamo%20Bay%20Prison%20Facility%20(1).pdf).

- The consequences of torture, which include combinations of psychiatric, neurological, musculoskeletal, genital, gastrointestinal, and other systems damage

Detainees lack meaningful access (and in many cases have no access at all) to independent medical experts

DOD has made clear that only those detainees involved in active litigation can access independent, civilian medical experts (IMEs).⁶ In practice, only a subset of those detainees has actually succeeded in doing so. So, while DOD may be accurate in stating that it has permitted “several hundred” meetings with IMEs, those represent only a handful of detainees.⁷

With regard to telehealth (i.e., remote access) – if implemented appropriately, the only reasonable and safe method for off-island medical personnel to visit detainees during the COVID-19 pandemic – we are not aware of any IME who has been afforded such an opportunity.

Moreover, as DOD has explained, IME’s “are not retained or appointed to treat detainees; rather, they assist the defense teams with medical matters related to litigation.”⁸ In other words, no detainee gets access to IMEs for the primary and obvious purpose for which they are needed: medical care. Even in the litigation context, few IMEs meet with detainees outside the presence of attorneys, most do not have access to medical equipment, and their advice and assistance has been restricted and subordinated to the authority of the assigned government providers—with whom IMEs have been precluded from meeting and conferring. The result is that IMEs advice and counsel has effectively been ignored.

The Defense Department has also stated that detainees have “24/7” access to board certified medical professionals, but those medical professionals frequently lack the experience, expertise, or resources to properly evaluate and treat the conditions for which IMEs are required. As discussed in more detail below, some detainees simply do not trust military-affiliated medical professionals. In neither case is that the fault of current front-line medical personnel, but it is reality.

Detainees lack meaningful access to their own medical records

It has not been our experience, nor is it our understanding, that outside the context of litigation detainees or their counsel have gotten the degree of access to medical records that DOD claims; far from it. Rather, we are aware of multiple detainees’ counsel who have repeatedly requested such access and repeatedly been denied.

For detainees who have received medical records in the context of litigation, production has been partial and often significantly delayed. Moreover, classification markings (or other forms of

⁶ DOD response to congressional oversight letter.

⁷ Id.

⁸ Id.

information protection) and redactions are more extensive than “the names or other personally identifying information of JTF-GTMO personnel.”⁹

To the extent DOD’s statement that “detainees’ medical records are disclosed to the detainees’ defense counsel through the discovery process” could be read to suggest a more comprehensive provision of records, it is misleading. No detainee charged in the military commissions or their counsel has full access to complete medical records. Military commission prosecutors, by contrast, have virtually unlimited access to charged detainees’ records.

Security-related policies and/or practices at times supersede or constrain medical professionals’ authority and decision-making

More than one detainee has reported that medical providers are explicitly directed not to inquire about conditions or history of trauma and stress. An Army psychiatrist previously stationed at Guantánamo has said similarly that mental health professionals there “weren’t allowed” to discuss with detainees their interrogation experiences, either at Guantánamo or with the CIA.¹⁰ Our experience is consistent with that omission, including that the medical records we have reviewed – some of detainees whose torture is detailed in the Senate Intelligence Committee’s report on the CIA’s Detention and Interrogation Program – are devoid of trauma histories. This outrageous practice has led to faulty diagnoses and improper treatment.

With respect to DOD’s statement that military medical professionals exercise “independent medical judgment,” our experience is that they cannot always do so, even if they wish to. We have experienced first-hand security-related policies and practices superseding or constraining medical professionals’ authority over certain decisions that have obvious medical repercussions, or otherwise overriding what is in detainees’ best medical interests.

Some detainees understandably do not trust military medical professionals

A trusting doctor-patient relationship is essential for meaningful consent to care, for reaching an accurate diagnosis based on complete information, and for providing effective treatment. It has been our repeated experience, however, that numerous detainees distrust military-affiliated medical professionals—a consequence of prior medical complicity in torture.

It is well documented that medical professionals were deeply complicit in torture inflicted as part of the CIA’s Rendition, Detention and Interrogation Program. Most recently, Majid Khan – a detainee held for three years at CIA black sites – described being raped with a garden hose by a CIA medic under the guise of so-called “rectal rehydration.”¹¹ At Guantánamo, at least during the years when substantial intelligence gathering efforts occurred there, medical personnel from the detainee hospital supported interrogations, including those employing torture and cruel,

⁹ Id.

¹⁰ Sheri Fink, Where Even Nightmares Are Classified: Psychiatric Care at Guantánamo, NY Times, Nov. 12, 2016, available at <https://www.nytimes.com/2016/11/13/world/Guantánamo-bay-doctors-abuse.html>.

¹¹ Carol Rosenberg, For First Time in Public, a Detainee Describes Torture at C.I.A. Black Sites, NY Times, Oct. 28, 2021, available at <https://www.nytimes.com/2021/10/28/us/politics/guantanamo-detainee-torture.html>.

inhuman, and degrading treatment.¹² They conducted medical screenings to determine detainees' "suitability" for interrogation,¹³ provided emergency medical support, and sometimes observed interrogations.¹⁴ That legacy will forever burden even the most well-intentioned military medical professionals at Guantánamo.

The rapid rotation of medical personnel on and off the base, and the challenges it creates for any real continuity of care, exacerbate this trust deficit.

Recommendations

Guantánamo must be closed. As long as the detention facility remains open, in order to mitigate the above-described medical care deficiencies, we recommend the following:

- Identify and immediately begin the process of transferring out of Guantánamo any detainee who Guantánamo cannot provide evaluation and treatment that is accepted by medical experts and reflected in peer-reviewed medical literature as the appropriate medical approach for the relevant condition, symptoms, illness, and/or disease and that is widely used by health care professionals; or
- Allow IMEs meaningful and regular access to Guantánamo, including permitting them to evaluate detainees in an appropriate setting – without the use of restraints and outside the presence of any other personnel – and to have timely access to all medical records, subject to detainees' consent.
- Declassify any medical records that have already been classified and discontinue classifying medical records going forward. Limit any redactions in medical records to legitimate identifiers of government personnel when the government can demonstrate that the redactions meet the requirements of Executive Order 13526.
- Upon a detainee's request, including requests made by counsel with the detainee's consent, provide the detainee with timely access to any and all of his own medical records generated or maintained by DOD and/or the CIA.

¹² Senate Armed Services Committee, *Inquiry Into the Treatment of Detainees in U.S. Custody* (2008) at 38-39, available at https://www.armed-services.senate.gov/imo/media/doc/Detainee-Report-Final_April-22-2009.pdf; Physicians for Human Rights, *Leave No Marks: Enhanced Interrogation Techniques and the Risk of Criminality*, August 1, 2007, available at <https://phr.org/resources/leave-no-marks/>; Report of The Constitution Project Task Force on Detainee Treatment (2013) at Chapter 6: The Role of Medical Professionals in Detention and Interrogation Operations, available at https://detainee-taskforce.org/pdf/Chapter-6_Role-of-Medical-Professionals.pdf.

¹³ Review of Department of Defense Detention Operations and Detainee Interrogations ("The Church Report") (March 7, 2005) at 140 ("The April 2003 GTMO Policy specified conditions for the use of these techniques, including, 'The detainee is medically and operationally evaluated as suitable (considering all techniques to be used in combination)"; Detention Medical Interface with Behavioral Science Consultation Team at 1 (February 15, 2005) ("BSCT staff may check directly with Detention Medical clinical staff to confirm whether or not a detainee is medically fit for interrogation activities.").

¹⁴ Assessment of Detainee Medical Operations for OEF, GTMO, and OIF at 18-2, Office of the Surgeon General (April 15, 2005) ("Medics randomly observe interrogations and have the ability to halt an interrogation at any point they deem necessary.").

- Lift the current legislative ban on transferring detainees to the United States, at a minimum for any detainee for whom Guantánamo cannot provide evaluation and treatment that is accepted by medical experts and reflected in peer-reviewed medical literature as the appropriate medical approach for the relevant condition, symptoms, illness, and/or disease and that is widely used by health care professionals.

Thank you again for the opportunity to submit this statement and for considering our views. We would be happy to meet with Committee Members to discuss our concerns further. Please contact Scott Roehm, Washington Director at the Center for Victims of Torture (sroehm@cvt.org), if the Committee would like to arrange such a meeting.

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Center for Victims of Torture

CVT is the oldest and largest torture survivor rehabilitation center in the United States and one of the two largest in the world. Through programs operating in the U.S., the Middle East, and Africa, CVT annually rebuilds the lives of tens of thousands of primary and secondary survivors. CVT also conducts research, training, and advocacy.