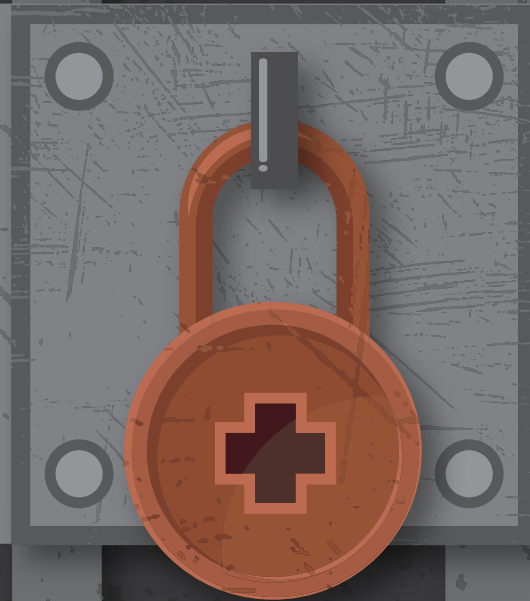


DEPRIVATION AND DESPAIR:

The Crisis of Medical Care at Guantánamo



The
CENTER for
VICTIMS of
TORTURE



Physicians for
Human Rights

THE CENTER FOR VICTIMS OF TORTURE

Founded in 1985 as the first torture survivor rehabilitation center in the United States, the Center for Victims of Torture (CVT) is the largest organization of its kind in the world. Through programs operating in the United States, the Middle East, and Africa—involving psychologists, social workers, physical therapists, physicians, psychiatrists, and nurses—CVT annually rebuilds the lives of nearly 25,000 primary and secondary survivors.

CVT also conducts research, training, and advocacy, with each of those programs rooted in CVT's healing services. The organization's policy advocacy leverages the expertise of five stakeholder groups: survivors, clinicians, human rights lawyers, operational/humanitarian aid providers, and foreign policy experts.

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Physicians for Human Rights (PHR) was founded in 1986 on the idea that health professionals, with their specialized skills, ethical duties, and credible voices, are uniquely positioned to stop human rights violations. For more than 30 years, PHR—which shared in the 1997 Nobel Peace Prize for its work to end the scourge of landmines—has used its investigations and expertise to advocate for persecuted health workers and facilities under attack, prevent torture, document mass atrocities, and hold those who violate human rights accountable.

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EXECUTIVE SUMMARY

From the inception more than 17 years ago of the Guantánamo Bay detention center located on the U.S. naval base in Guantánamo Bay, Cuba, senior detention facility personnel have consistently lauded the quality of medical care provided to detainees there. For example, in 2005, Joint Task Force (JTF) Guantánamo's then-commander said the care was "as good as or better than anything we would offer our own soldiers, sailors, airmen or Marines." In 2011, a Navy nurse and then deputy command surgeon for JTF Guantánamo made a similar claim: "The standard of care here is the best possible standard of care (the detainees) could get." In late 2017, Guantánamo's senior medical officer again echoed those sentiments: "Detainees receive timely, compassionate, quality healthcare...[which is]...comparable to that afforded our active duty service members on island."

There have been many more such assertions in the intervening years and since. Following an in-depth review of publicly available information related to medical care at Guantánamo—both past and present—as well as consultations with independent civilian medical experts and detainees' lawyers, the Center for Victims of Torture and Physicians for Human Rights have determined that none of those assertions is accurate.

To the contrary, notwithstanding Guantánamo's general inaccessibility to independent civilian medical professionals, over the years a handful of them have managed to access detainees, review medical records, and interface with Guantánamo's medical care system to a degree sufficient to document a host of systemic and longstanding deficiencies in care. These include:

- Medical needs are subordinated to security functions. For example, prosecutors in a military commission case told the judge explicitly that the commander of Guantánamo's detention operations is free to disregard recommendations of Guantánamo's senior medical officer.
- Detainees' medical records are devoid of physical and psychological trauma histories. This is largely a function of medical professionals' inability or unwillingness to ask detainees about torture or other traumatic experiences during their time in the CIA's rendition, detention, and interrogation program, or otherwise with respect to interrogations by U.S. forces—which has led to misdiagnoses and improper treatment.
- In large part due to a history of medical complicity in torture, many detainees distrust military medical professionals which has led repeatedly to detainees reasonably refusing care that they need.

- Guantánamo officials withhold from detainees their own medical records, including through improper classification.
- Both expertise and equipment are increasingly insufficient to address detainees' health needs. For example, a military cardiologist concluded that an obese detainee required testing for coronary artery disease, but that Guantánamo did not have the "means to test" him, and so the testing was not performed. With regard to mental health, effective torture rehabilitation services are not, and cannot be made, available at Guantánamo.
- Detainees have been subjected to neglect. One detainee urgently required surgery for a condition he disclosed to Guantánamo medical personnel in 2007—and they diagnosed independently in 2010—but he did not receive surgery until 2018 and appears permanently damaged as a result.
- Military medical professionals rotate rapidly in and out of Guantánamo, which has caused discontinuity of care. For example, one detainee recently had three primary care physicians in the course of three months.
- Detainees' access to medical care and, in some cases, their exposure to medical harm, turn substantially on their involvement in litigation. For example, it appears extremely difficult, if not impossible, for detainees who are not in active litigation to access independent civilian medical professionals, and for those who are to address a medical need that is not related to the litigation. For detainees charged before the military commissions, prosecution interests have superseded medical interests, as with a detainee who was forced to attend court proceedings on a gurney writhing in pain while recovering from surgery.

These deficiencies are exacerbated by—and in some cases a direct result of—the damage that the men have endured, and continue to endure, from torture and prolonged indefinite detention.

It is long past time that the medical care deficiencies this report describes were acknowledged and addressed. Systemic change is necessary; these are not problems that well-intentioned military medical professionals—of which no doubt there are many, working now in an untenable environment—can resolve absent structural, operational, and cultural reform. Nor, in many respects, are they problems that can be fully resolved as long as the detention facility remains open.

Guantánamo should be closed. Unless and until that happens, the Center for Victims of Torture and Physicians for Human Rights call upon Congress, the Executive Branch, and the Judiciary to adopt a

series of recommendations aimed at meaningfully improving the status quo. These include, but are not limited to: lifting the legal ban on transferring detainees to the United States and mandating such transfers when detainees present with medical conditions that cannot be adequately evaluated and treated at Guantánamo; ensuring detainees have timely access to all of their medical records upon request while otherwise maintaining confidentiality of those records (especially with regard to access by prosecutors); and allowing meaningful and regular access to Guantánamo by civilian medical experts, including permitting such experts to evaluate detainees in an appropriate setting.

If the United States declines to take the steps this report recommends, complex medical conditions that cannot be managed at Guantánamo should be expected to accelerate in frequency and escalate in severity.

INTRODUCTION

The Guantánamo Bay detention center, located on the U.S. naval base in Guantánamo Bay, Cuba, is now in its eighteenth year. Forty Muslim men still languish there, 31 of whom have never been charged with a crime.¹ Five detainees have long been cleared for transfer by consensus of the Executive Branch's national security apparatus, which determined that the men pose no meaningful threat, if any at all, to the United States. Many of the remaining detainees are torture survivors or victims of similarly significant trauma. All of them are either suffering from or at high risk of the additional profound physical and psychological harm associated with prolonged indefinite detention, a form of cruel, inhuman, and degrading treatment. As the men age under these conditions, they are increasingly presenting with complex medical needs.

Indeed, on April 27, 2019, then Joint Task Force-Guantánamo (JTF-GTMO) Commander Rear Admiral John C. Ring expressed concern to a gathering of reporters about Guantánamo's ability to provide medical care to the remaining detainees as time passes and with seemingly no prospect of their release:

*Unless America's policy changes, at some point we'll be doing some sort of end of life care here.... A lot of my guys are prediabetic.... Am I going to need dialysis down here? I don't know. Someone's got to tell me that. Are we going to do complex cancer care down here? I don't know. Someone's got to tell me that.*²

His statements echo those of General John F. Kelly, United States Marine Corps, former Commanding General United States Southern Command, who testified *six years prior*, 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."³ General Kelly explained that "the medical issues of the aging detainee population are increasing in scope and complexity," and that "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.⁴

Both Admiral Ring and General Kelly are correct: Guantánamo is unprepared to address the medical needs of an aging population, especially given current U.S. laws that prohibit transferring any of the men to the United States for any reason. But the medical care problems at Guantánamo are far more serious and run much deeper.

Although independent civilian medical experts have had limited direct access to detainees, their experiences interfacing with Guantánamo's medical care system—coupled with review of available

medical records and information provided by detainees' legal counsel—have been sufficient for them to document multiple significant deficiencies that cut across the detainee population.

Many of the deficiencies are structural, like the subordination, whether through policy or practice, of detainees' medical needs to security functions. Or the lack of expertise and equipment necessary to provide adequate care for medical conditions that are inevitable in a population of torture survivors⁵ who have been detained for almost two decades in a facility synonymous with torture and who are suffering the profound health consequences of both. Or the frequent rotation of medical personnel on and off the island which makes continuity of care all but impossible. Or the deeply troubling double standard by which detainees cannot meaningfully access their own medical records, while prosecutors in military commission cases can.

Some of the medical care deficiencies amount to substandard care on their face. For example, there appears to be a widespread practice of medical professionals not asking detainees about (or at least not documenting) torture and abuse they suffered at CIA black site prisons, where some were held captive for years following the September 11, 2001 attacks. This failure has resulted in an absence of trauma histories in detainees' medical records and, in turn, has led to inaccurate diagnoses and improper treatment.

**CLICK TO GO TO
THE CASE STUDIES**

Each of these deficiencies, among others, is described in detail in the body of this report, and further illustrated in the case studies that follow.

Some detainees have reported positive experiences with medical care at Guantánamo, including constructive relationships with nurses and doctors and in some cases medical staff responding quickly to life-threatening illness.⁶ Moreover, it is clear that many military medical professionals are doing their best under nearly impossible circumstances. But in neither case does that diminish the seriousness of the problems identified in this report.

The case that perhaps best illustrates the state of medical care at Guantánamo is that of Abd al-Hadi al-Iraqi (aka Nashwan al-Tamir), who was captured in 2006, rendered to a CIA black site, then transferred to Guantánamo the following year. On September 5, 2018, Mr. al-Tamir collapsed incontinent in his cell from a degenerative spinal condition—one about which he had told Guantánamo's medical personnel more than 10 years earlier, they had independently diagnosed at Guantánamo in 2010, and that outside medical experts concluded had obviously required urgent surgical intervention years earlier. To avoid paralysis, a team of specialists from the mainland had to fly to Guantánamo on a moment's notice

**CLICK TO
SEE THE
AL-TAMIR
CASE STUDY**

and perform emergency surgery. Four additional surgeries later—all performed at Guantánamo, but again by off-island specialists—Mr. al-Tamir’s spinal condition is still not resolved, he continues to suffer, and he may require additional surgery.

Nevertheless, the government has pushed forward with Mr. al-Tamir’s prosecution in the military commissions, which has required him to attend court on a gurney, take pain medication during legal proceedings, and sleep in the courtroom when the predictable effects of that medication set in. Because of Mr. al-Tamir’s fragile state, Guantánamo’s senior medical officer repeatedly recommended that Mr. al-Tamir not be forcibly extracted from his cell to attend court proceedings (or otherwise). Prosecutors assured the judge in Mr. al-Tamir’s case that he did not need to issue an order to the same effect because Guantánamo’s non-medical staff would respect the recommendation. They were wrong. At the next hearing, prosecutors conceded that, in fact, Guantánamo’s non-medical commanders “are not bound by the [senior medical officer’s] opinions nor will they defer to them in every instance.”⁷

The medical care situation at Guantánamo is not sustainable and should be expected to worsen rapidly over time as the impacts of both torture and indefinite detention exacerbate medical complications otherwise associated with aging. This report concludes with a series of recommendations that would at least mitigate medical care deficiencies and reduce the likelihood of unmanageable medical crises until Guantánamo—as it should be—is finally closed.

METHODOLOGY AND LIMITATIONS

This report by the Center for Victims of Torture and Physicians for Human Rights is based on an analysis of public source materials documenting significant deficiencies in the provision of medical care to detainees at Guantánamo. The materials include litigation filings in military commission cases and federal court habeas corpus proceedings, filings before the Guantánamo Periodic Review Boards, press reports, and other publicly available sources. The report also draws on 15 years of both organizations' experience examining the CIA's former rendition, detention, and interrogation program, the establishment and spread of torture and cruel, inhuman, and degrading treatment in the military in the aftermath of the September 11, 2001 attacks, and the role of U.S. health professionals in detainee torture and abuse.

To supplement and contextualize the public source materials, the report's authors consulted with independent civilian medical experts—several of whom have significant experience conducting medical and psychological evaluations of Guantánamo detainees, reviewing their available medical records, and interfacing with Guantánamo's medical care system—as well as with counsel for detainees.

The report does not claim to provide a comprehensive examination of medical care at Guantánamo, nor could it. Many detainees themselves are unable to access their own medical records, or, in the absence of active litigation (and sometimes even then), to secure a medical evaluation by a civilian health professional. Independent civilian health professionals have had, and continue to have, limited access to Guantánamo. Some detainees refuse medical care due to concern over access to their records by prosecutors in military commission cases. And, according to detainees' counsel, significant portions of medical records the government has produced are classified.

STANDARD OF CARE

From the day Guantánamo opened, the United States has claimed that neither longstanding international law nor well-settled domestic law applies there, a position widely condemned by the international community. U.S. courts have firmly resolved some basic legal questions, like affirming detainees' right to challenge the legality of their detention through habeas corpus petitions in federal court.⁸ Other foundational decisions are becoming more unstable over time, such as the authority to detain men at Guantánamo at all, which the Supreme Court said could “unravel” if “the practical circumstances” of the war against al-Qaida and the Taliban became “unlike those of the conflicts that informed the development of the law of war.”⁹ Still other fundamental legal questions have yet to be decided, including whether the Constitution applies at Guantánamo.¹⁰

This report does not engage that legal debate with respect to medical care obligations because, even by the standards that the United States has embraced, the deficiencies the report describes constitute clear violations.

Specifically, as noted at the outset, military officials have claimed repeatedly that detainees receive medical care equivalent to that which Guantánamo's Joint Medical Group—the entity responsible for medical care at the naval base—provides to service members.¹¹ That position is reflected in U.S. Army Regulation 190–8, which implements the Geneva Conventions and “provides policy, procedures, and responsibilities for the administration, treatment, employment, and compensation of enemy prisoners of war ... retained personnel ... civilian internees ... and other detainees in the custody of U.S. Armed Forces.”¹² For example, the regulation states that prisoners of war and retained personnel “will be quartered under conditions as favorable as those for the force of the detaining power billeted in the same area.”¹³ The rules for civilian internees reflect the same principle: “Patients requiring hospital treatment will be moved, if feasible, to a civilian hospital. The treatment must be as good as that provided for the general population.”¹⁴

The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), which the United States has championed,¹⁵ state similarly that “[p]risoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.”¹⁶ By their terms, the Mandela Rules are “applicable to all categories of prisoners, criminal or civil, untried or convicted, including prisoners subject to ‘security measures.’”¹⁷ The rules provide more detailed benchmarks that inform an assessment of whether, as one former Guantánamo commander asserted, detainees receive “first-rate” medical care that is “as good as or better than anything we would offer our

own soldiers, sailors, airmen or Marines.”

The following Mandela Rules are of particular relevance to the deficiencies identified in this report:

- **Rule 8:** The following information shall be entered in the prisoner file management system in the course of imprisonment, where applicable:
...
(d) Requests and complaints, including allegations of torture or other cruel, inhuman or degrading treatment or punishment, unless they are of a confidential nature.
- **Rule 9:** All records ... shall be kept confidential and made available only to those whose professional responsibilities require access to such records. Every prisoner shall be granted access to the records pertaining to him or her, subject to redactions authorized under domestic legislation, and shall be entitled to receive an official copy of such records upon his or her release.
- **Rule 24:** 1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status. 2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care.
- **Rule 25:** 1. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation. 2. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry.
- **Rule 26:** 1. The health-care service shall prepare and maintain accurate, up-to-date and confidential individual medical files on all prisoners, and all prisoners should be granted access to their files upon request. A prisoner may appoint a third party to access his or her medical file. 2. Medical files shall be transferred to the health-care service of the receiving institution upon transfer of a prisoner and shall be subject to medical confidentiality.
- **Rule 27:** 1. All prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or

to civil hospitals. Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide prisoners referred to them with appropriate treatment and care.

2. Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff.

- **Rule 30:** A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary. Particular attention shall be paid to: (a) Identifying health-care needs and taking all necessary measures for treatment; (b) Identifying any ill-treatment that arriving prisoners may have been subjected to prior to admission; (c) Identifying any signs of psychological or other stress brought on by the fact of imprisonment, including, but not limited to, the risk of suicide or self-harm.
- **Rule 31:** The physician or, where applicable, other qualified health-care professionals shall have daily access to all sick prisoners, all prisoners who complain of physical or mental health issues or injury and any prisoner to whom their attention is specially directed. All medical examinations shall be undertaken in full confidentiality.
- **Rule 32:** 1. The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, in particular: (a) The duty of protecting prisoners' physical and mental health and the prevention and treatment of disease on the basis of clinical grounds only; (b) Adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship; (c) The confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others; (d) An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment.
- **Rule 34:** If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm.
- **Rule 47:** 1. The use of chains, irons or other instruments of restraint which are inherently

degrading or painful shall be prohibited. 2. Other instruments of restraint shall only be used when authorized by law and in the following circumstances: (a) As a precaution against escape during a transfer, provided that they are removed when the prisoner appears before a judicial or administrative authority; (b) By order of the prison director, if other methods of control fail, in order to prevent a prisoner from injuring himself or herself or others or from damaging property; in such instances, the director shall immediately alert the physician or other qualified health-care professionals and report to the higher administrative authority.

- **Rule 57:** 1. Every request or complaint shall be promptly dealt with and replied to without delay. If the request or complaint is rejected, or in the event of undue delay, the complainant shall be entitled to bring it before a judicial or other authority. 2. Safeguards shall be in place to ensure that prisoners can make requests or complaints safely and, if so requested by the complainant, in a confidential manner. A prisoner or other person [authorized to make a request or complaint on the prisoner's behalf] must not be exposed to any risk of retaliation, intimidation or other negative consequences as a result of having submitted a request or complaint. 3. Allegations of torture or other cruel, inhuman or degrading treatment or punishment of prisoners shall be dealt with immediately and shall result in a prompt and impartial investigation conducted by an independent national authority in accordance with paragraphs 1 and 2 of rule 71.

DEFICIENCIES IN MEDICAL CARE

The absence of an effective firewall between medical and security operations, Guantánamo's sordid history, and the widespread prevalence of trauma due to torture among the detainee population have created or exacerbated a variety of serious deficiencies in medical care, described below.

**CLICK TO GO TO
THE CASE STUDIES**

These deficiencies are further illustrated in four case studies, representing current and former detainees, which can be found at the end of this report.

Health conditions are also worsened by the prolonged, indefinite detention of those confined at Guantánamo, a form of abuse that has been extensively documented to carry severe and long-lasting health consequences and that the United Nations Special Rapporteur on Torture has determined constitutes cruel, inhuman, and degrading treatment.¹⁸

Unless and until these problems are acknowledged, understood, and addressed, complex medical conditions that cannot be managed at Guantánamo should be expected to accelerate in frequency and escalate in severity.

Subordination of medical needs to security functions

Mr. Dhiab appropriately requested analgesic medication for his pain in a form that he would have been able to ingest, but was refused by the nurse provider. Furthermore, the nurse and accompanying assistant judge advocate (ASJA) reported that the attending physician refused to see Mr. Dhiab to discuss treatment of his pain and prescription of medications. The nurse and staff claimed that they were abiding by Standard Operating Procedures (SOPs) stipulating the terms of interactions with detainees.

– Brigadier General (Ret) Stephen N. Xenakis, MD

From Guantánamo's inception, security-related policies and practices have superseded or constrained medical professionals' authority over certain decisions that have obvious medical repercussions, and repeatedly overridden what is in detainees' best medical interests.

For example, the 2004 standard operating procedure for one of Guantánamo's early prison complexes

specified that medical orders would only be complied with if they did not cause a security violation—“such as serving an extra meal”—unless the violation had been pre-approved by the guard force.¹⁹ It also required detainees to be restrained even in the operating room (unless sedated), and to be shackled during medical examinations in their cells.²⁰ Seemingly pursuant to that SOP, Saifullah Paracha was shackled to his bed by all four limbs while being treated for a heart condition in 2006, notwithstanding the Joint Medical Group doctor’s judgment that he needed to ambulate while recovering.²¹

According to one independent medical expert, detainees have reported “that [Joint Medical Group personnel] will order a medically necessary item, such as an extra blanket but this will not be given to them either because the [Joint Detention Group, which is responsible for detention operations at Guantánamo], misplaces the order or overrides it. Detainees report that some [Joint Medical Group personnel] are apologetic for not being able to practice medicine independent of [the Joint Detention Group’s] participation.”²²

Independent physicians Brigadier General (Ret) Stephen N. Xenakis, MD, and Sondra Crosby, MD—medical experts for Physicians for Human Rights who together have spent more than 1,000 hours at Guantánamo and evaluating detainees and their medical records—personally witnessed this problem on a visit to Guantánamo in late 2014 to conduct a neuropsychiatric assessment of former detainee Abu Wa’el (Jihad) Dhiab. Their evaluation included observing Mr. Dhiab’s interactions with healthcare providers during one session when he complained of severe back pain.

Mr. Dhiab appropriately requested analgesic medication for his pain in a form that he would have been able to ingest, but was refused by the nurse provider. Furthermore, the nurse and accompanying assistant judge advocate (ASJA) reported that the attending physician refused to see Mr. Dhiab to discuss treatment of his pain and prescription of medications. The nurse and staff claimed that they were abiding by Standard Operating Procedures (SOPs) stipulating the terms of interactions with detainees.²³

Present day policies and practices at Guantánamo demonstrate that detention-related decisions continue to supersede appropriate care generally and medical recommendations specifically. Mr. al-Tamir’s treatment again provides an example: In 2017, he was subjected to a forced cell extraction while suffering increasingly serious symptoms that foreshadowed the series of emergency back surgeries he would receive later the following year.²⁴ On February 7, 2018 (and again on March 1 and March 22) Guantánamo’s senior medical officer concluded that “[a]bsent extraordinary circumstances, forced cell extraction of [Mr. al-Tamir] is not medically advised at this time.... From a medical standpoint, it should only be considered in cases where dire safety or immediate potential loss of life are foreseeable. I have relayed this information and my opinion to the Commander, Joint Detention Group.”²⁵ The prosecution team in Mr. al-Tamir’s military commission case then assured the judge that the “the [Joint Task Force]

commander and leadership is going to defer to the [Senior Medical Officer's] opinion."²⁶ That assurance stood for one month, at which point the government abruptly reversed course and explicitly conceded that the key structural obstacle to consistent provision of adequate medical care at Guantánamo persists:

"[While] the JTF-GTMO and [Joint Detention Group] Commanders will undoubtedly consider the [senior medical officer's] highly relevant and useful information...these Commanders are not bound by the [senior medical officer's] opinions nor will they defer to them in every instance."²⁷

Pervasive distrust stemming from prior medical complicity in torture

Trust in one's doctor is a necessary precondition to being forthcoming with information and consenting to care, which are in turn essential to making an accurate diagnosis and prognosis and providing effective treatment. It is problematic, if not impossible, for the standard doctor-patient relationship to develop at Guantánamo, thereby weakening the foundation of the standard practice of medicine—the establishment of trust in one's doctor. All personnel in Guantánamo, including medical staff, are perceived and experienced as part of the detainee's original torture project. In my experience, the possibility of developing trust in a doctor is virtually impossible for Guantánamo detainees....

– Jess Ghannam, MD

A trusting doctor-patient relationship is essential for meaningful consent to care, for reaching an accurate diagnosis based on full information, and for providing effective treatment.²⁸ As one medical expert put it: "[Trust is] the foundation of the standard practice of medicine."²⁹

At Guantánamo, building that foundation ranges from difficult to impossible, especially when it comes to military mental health professionals.³⁰ That is due in large measure to Guantánamo's legacy of torture. The Senate Armed Services Committee's 2008 report concluding its Inquiry Into the Treatment of Detainees in U.S. Custody (SASC Report) describes in detail how the task force at Guantánamo responsible for managing counterterrorism interrogations in support of military operations researched, developed, and implemented strategies to "break detainees."³¹ Medical professionals were deeply complicit in the torture and cruel, inhuman, and degrading treatment that resulted.³²

For example, at least during the years when substantial intelligence gathering efforts occurred at

Guantánamo, medical personnel from the detainee hospital supported interrogations, including those employing torture and cruel, inhuman, and degrading treatment.³³ They conducted medical screenings to determine detainees' "suitability" for interrogation,³⁴ provided emergency medical support, and sometimes observed interrogations.³⁵

The interrogations unit also controlled other medical personnel, their own psychiatrists and/or psychologists who advised interrogators on how to coerce detainees (the Behavioral Science Consultation Teams, or BSCTs).³⁶ According to Major Paul Burney, an Army psychiatrist, he and Major John Leso—an Army psychologist who led the BSCT from June 2002 to January 2003—"took turns observing the questioning ... of Mohammad al-Qahtani." As part of that so-called "questioning," multiple government investigators later found, al-Qahtani "was menaced with military dogs, draped in women's underwear, injected with intravenous fluids to make him urinate on himself, put on a leash and forced to bark like a dog, and interrogated for 18 to 20 hours at least 48 times."³⁷

Examples of detainees' reasonable distrust of military medical providers as a result of medical complicity in torture include:

- According to a psychiatrist/neurologist who provided an expert opinion to his Periodic Review Board, Ghaleb Al-Bihani—who was cleared for transfer out of Guantánamo in May 2014 and transferred in January 2017—episodically refused to meet with medical staff or to follow their treatment plans. "[M]any detainees have told me that it has been impossible to form a clinician-patient relationship with [Joint Medical Group] clinicians," the expert said, in no small part because "earlier involvement [in interrogations] has made it impossible for some detainees to trust [Joint Medical Group] clinicians who deliver care after this practice ended."³⁸
- In June 2016, Dr. Emily Keram—a psychiatrist and neurologist who evaluated Mohammed al-Qahtani for 39 hours over five days—concluded that "Mr. al-Qahtani cannot receive effective treatment for his current mental health conditions while he remains in US custody at GTMO ... despite the best efforts of available and competent clinicians." One of the factors that precludes effective treatment, she opined, is "lack of trust in the medical and mental health staff due to previous clinician involvement in interrogations."³⁹
- Sharqawi Al Hajj, who was both rendered to torture and subsequently abused at a CIA black site, similarly "refuses mental health care at Guantánamo for lack of trust."⁴⁰
- In 2012, the government flew a mobile cardiac unit in to Guantánamo to treat Saifullah Paracha, Guantánamo's oldest remaining detainee (now 71 years old). Especially given his previous experience

with cardiac treatment there (described above), Mr. Paracha refused care. He does not believe risks can properly be mitigated at Guantánamo or that he would be treated as a patient (versus as an “enemy combatant”).⁴¹

- In June of 2015, former detainee Tariq Ba Odah—who had been on a long-term hunger strike—weighed 74.5 pounds, approximately half his normal body weight. Multiple independent civilian medical experts opined that he required urgent and complex intervention. In a declaration filed in federal court, the senior medical officer, by contrast, concluded that Mr. Ba Odah was “clinically stable,” and explained that to the extent his conclusion lacked a strong evidence base that was because Mr. Ba Odah repeatedly refused care.⁴²

Three independent civilian medical experts filed declarations responding to the senior medical officer’s conclusion, each of which demonstrates not only the trust deficit (and its consequences) at Guantánamo, but also several other of the medical care deficiencies discussed in this report:

Dr. Jess Ghannam, in his declaration supporting Mr. Ba Odah’s petition for habeas relief, stated:

My clinical experience, training and basic standard-of-care principles leads me to the conclusion that the [senior medical officer’s] declaration regarding Mr. Ba Odah is flawed and reflects a strikingly inadequate response to Mr. Ba Odah’s reported condition. The [senior medical officer’s] course of treatment, as reported in his declaration, departs from the basic tenants[sic.] of diagnostic, preventative and remedial care, particularly for a patient who is so abnormally malnourished and underweight as Mr. Ba Odah. It is difficult, if not impossible, to have confidence in the conclusions it draws about his physical and mental state....⁴³

It is important to note that, however implausible the scenario may be in the Guantánamo context, medical ethical guidelines are explicit that when a patient expresses mistrust in their caregiver—either directly or through their behavior—it becomes that doctor’s professional (indeed moral) responsibility to transfer that patient to another competent, trusted doctor who can properly treat the patient. So, though the [senior medical officer’s] declaration builds a record of his efforts to provide care to Mr. Ba Odah, the ethical guidelines governing the practice of medicine actually require that the [senior medical officer] facilitate Mr. Ba Odah’s access to competent care from another physician.⁴⁴

In her declaration supporting Mr. Ba Odah's petition, Dr. Sondra Crosby stated:

[G]iven that the medical staff at Guantánamo orders and processes Mr. Ba Odah's forcible feeding (which, as the [senior medical officer] acknowledges, may include forced cell extractions), it is reasonable and common that Mr. Ba Odah would regard them as coercive and part of the prison structure. Nothing in the [senior medical officer's] declaration changes my assessment that Mr. Ba Odah's distrust of Guantánamo medical staff is reasonable.⁴⁵

Nothing in the [senior medical officer's] declaration causes me to alter my original opinion signed on June 22, 2015, concluding that Mr. Ba Odah, by virtue of his extremely low 74-pound weight and as-yet undiagnosed symptomology, is suffering from the grave consequences of severe malnutrition and that he is in need of medical intervention by independent and trusted medical personnel in order to limit the risk of death or disability he currently faces. Indeed, the [senior medical officer's] declaration furthers my concern, insofar as it affirms that Mr. Ba Odah is at a dangerously low weight (and has been for nearly a year), that he has not been adequately evaluated or treated, and that his understandable distrust of the Guantánamo medical staff is preventing the possibility of treatment and recovery. I also consider several aspects of the [senior medical officer's] assessment, particularly his summary conclusion that Mr. Ba Odah is "clinically stable," to be based on insufficiently reliable clinical data that cannot form the basis of a medically responsible judgment.⁴⁶

Dr. Rami Bailony's declaration supporting the petition stated:

Nothing in the [senior medical officer's] declaration indicates that he performed the predicate analysis that would justify his conclusion that Mr. Ba Odah is clinically stable, other than reportedly checking Mr. Ba Odah's vital signs on one occasion roughly four months before the [senior medical officer's] declaration was signed. Indeed, the reported observations of Mr. Ba Odah point to precisely the opposite determination. To be more direct, in my experience, a physician would not assess a patient to be clinically stable based merely on the outward appearance of "normal" behavior or functioning. There are numerous diseases—particularly in cases of chronic, severe malnourishment—that do not appear to interfere with normal human functioning until they progress to their final, lethal stages.⁴⁷

Other security-related policies and practices that have at times overridden detainees' medical needs, described in the previous subsection, have also contributed to detainees' distrust of Guantánamo medical providers.

Discontinuity of care

Several independent civilian medical experts have noted the rapid rotation of medical personnel at Guantánamo, the challenges it creates for any real continuity of care, and how it intensifies the trust deficit described above.⁴⁸ For instance, Mr. al-Tamir had three different primary care physicians between January and March 2019. According to one medical expert, "Detainees have often told me that they occasionally have a clinician whom they perceive as interested and helpful in their care, and that it is painful for them when these clinicians rotate out of GTMO and a new clinician takes their place."⁴⁹ The lack of continuity of care is especially problematic in the context of mental health care.

Medical records devoid of torture/trauma histories

Based on my assessment and vast experience caring for survivors of torture, the physical and mental health care afforded to [Mr. Al Nashiri] is woefully inadequate to his medical needs. A significant factor in my opinion is that medical professionals, including mental health care providers, have apparently been directly or indirectly instructed not to inquire into the causes of Mr. Al-Nashiri's mental distress, and as a consequence, he remains misdiagnosed and untreated.

– Sondra Crosby, MD

There appears to be a widespread practice of Joint Medical Group personnel, including mental health professionals, not inquiring into detainees' experiences in the CIA's rendition, detention and interrogation program, or otherwise with respect to detainees' interrogation by U.S. forces.⁵⁰

Indeed, according to Dr. Michael Fahey Traver, an Army psychiatrist stationed at Guantánamo in 2013 and 2014, mental health professionals understood that they were not to ask about a detainee's interrogation experiences, either at Guantánamo or with the CIA. "You just weren't allowed to talk about those things, even with them," he said. If a detainee raised the subject of his prior treatment, Dr. Traver said his predecessor had told him "to redirect the conversation."⁵¹

That omission is critical. Decades of extensive medical and psychological literature demonstrate that

torture and ill treatment can result in severe health consequences potentially affecting every aspect of the body and mind. Uncovering such trauma exposure is essential to documenting adequate and accurate medical history and to the treatment of patients.

Not surprisingly, failure to do so has led to misdiagnoses, improper treatment, and/or lack of treatment. The most prominent publicly available example, described in detail in his case study, is that of Abd al-Rahim al-Nashiri. The declassified executive summary of the Senate Select Committee on Intelligence’s study of the CIA’s former detention and interrogation program described in painful detail Mr. al-Nashiri’s torture, and yet—at least through April of 2014—no Guantánamo medical professional had ever recorded a trauma history in his records. As such, Dr. Crosby explains that Mr. al-Nashiri has been suffering for years with untreated Post Traumatic Stress Disorder (PTSD), including at times being punished for behaviors that are in fact symptoms of his PTSD.⁵²

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This hole in detainees’ medical records also impacts doctors’ ability to diagnose and properly treat physical conditions. These include musculoskeletal pain (e.g., in a detainee’s shoulders, from having had his wrists shackled behind his back and then being hung from his arms); traumatic brain injury (e.g., from repeated blows to the head); or damage resulting from what the CIA euphemistically described as “rectal feeding” (i.e., pumping food into a detainee’s rectum through a tube forced into his anus against his will).

Rapid rotation of medical personnel and resulting lack of continuity of care also make it more difficult to create and maintain comprehensive, accurate medical records.

Withholding of medical records, including through improper classification

Further complicating al Hawsawi’s medical treatment is the classification of much of his medical records. Navy Cmdr. Walter Ruiz, who represents al Hawsawi, says that the records his team does get access to are incomplete, provided on a sixth-month delay and are partially redacted.

– Jessica Schulberg, Huffington Post

There are two inter-related problems with access to medical records at Guantánamo: the government’s general reluctance to turn detainees’ own records over to them and the extent to which medical records are classified.

Access to one's personal medical information is a basic right recognized in medical policy guidelines.⁵³ And yet detainees' counsel, both in the habeas context and before the military commissions, routinely report that requests for medical records made on behalf of their clients (and so obviously with their clients' consent) are denied outright or result in partial production after significant delay.

For example, for two years the government refused to provide medical records to counsel for Tarek el-Sawah.⁵⁴ As of this writing, the government was still fighting Mr. Al Hajj's request for medical records in federal court.⁵⁵ An independent expert who examined Mustafa Muhammad Abu Faraj al-Libi in person was not permitted to review his then-current medical records.⁵⁶ And, notwithstanding the cascade of medical crises that Mr. al-Tamir has suffered (referenced above and described in detail in his case study), even his counsel still does not have a comprehensive set of his medical records.

Improper classification appears to be a contributor to the access problem, at least for some detainees. Numerous counsel have reported that substantial portions of their clients' records are marked "classified"—sometimes at the highest level⁵⁷—and that, as such, even military medical providers at Guantánamo may not be able to review those records unless they have the necessary security clearance; in some cases, they may be prohibited from meeting alone with certain detainees.

Pursuant to Executive Order 13526, information can only be classified if its "unauthorized disclosure ... reasonably could be expected to result in damage to the national security, which includes defense against transnational terrorism, and the original classification authority is able to identify or describe the damage... If there is significant doubt about the need to classify information, it shall not be classified."⁵⁸ Applying that standard, it is difficult to understand how a detainee's medical record could properly be classified, especially given the absence of redactions relating to treatment of detainees in CIA custody in both the declassified executive summary of the Senate Select Committee on Intelligence study of the CIA's former detention and interrogation program and the CIA's response to that study.⁵⁹

Lack of medical capabilities

Often times certain basic diagnostic tests are not possible because no such facilities exist, and non-detainee individuals are forced to leave to have appropriate diagnostic work-ups. Additionally, certain laboratory tests have to be sent off-island because the facilities at Guantánamo are not equipped to carry out these tests.

– Jess Ghannam, MD

As General Kelly warned six years ago, Guantánamo simply does not have the capability—with respect to either expertise or equipment—to address appropriately the medical issues that detainees are facing. These issues include both psychiatric and physical traumas that medical examinations have documented are associated with prolonged indefinite detention.⁶⁰ Examples of insufficient capability include:

- Guantánamo lacks culturally informed treatment modalities;⁶¹
- Torture rehabilitation services are not available at Guantánamo, both because medical providers there do not possess the necessary expertise to deliver that care and because, in many ways, the setting is the antithesis of what is required for effective treatment, which includes:
 - › Providing a sense of control to the victim over key features of the rehabilitation context, content, and process;
 - › Restoring a felt sense of safety as it pertains to the internal physiological state and external habitat of the victim, including adequate management of pain;
 - › Providing the victim with trusted human connections that are consistently available, including regular predictable access to the treatment provider(s) and regular meaningful access to other trustworthy sources of social support; and
 - › The treating provider(s) must be sufficiently skilled and experienced in treating severe trauma explicitly designed and perpetrated by other human beings.⁶²
- Guantánamo has never had a permanent, functional MRI machine with a technician capable of performing the MRI and a radiologist capable of reading the results.⁶³
- According to Dr. Ghannam, “Often times certain basic diagnostic tests are not possible because no such facilities exist, and non-detainee individuals are forced to leave to have appropriate diagnostic work-ups. Additionally, certain laboratory tests have to be sent off-island because the facilities at Guantánamo are not equipped to carry out these tests.”⁶⁴
- Guantánamo medical providers, as well as independent civilian medical experts, have on numerous occasions recommended medical tests that cannot be performed, or treatment that cannot be delivered, at Guantánamo.⁶⁵

- At times, seemingly appropriate testing will occur, but the results produced to independent civilian medical experts are insufficient. For example, in Mr. Dhiab's case, a "CT scan provided by Guantánamo contained approximately 8 images and [was] inadequate for assessment of Mr. Dhiab's complaints, injuries, and conditions."⁶⁶ It is unclear to what extent this is a problem attributable to medical capabilities, the records access issue discussed above, or a combination of both.
- Independent civilian medical experts' experience is that the senior medical officers tend to be relatively junior for the post to which they are assigned, and as such are put in a position of responsibility over complex medical situations some of which may be beyond their ability and expertise.
- Guantánamo lacks specialists in a host of areas that are becoming increasingly relevant as the detainee population ages and medical needs become more complex. This includes insufficient capability to address the complex mental health needs of a population suffering the profound psychological distress associated with prolonged indefinite detention.⁶⁷

This is only an illustrative list. The equipment and expertise required to provide consistent, adequate care at Guantánamo will grow over time.

Neglect

[T]he lack of diagnostic pursuits (despite recommendations by Guantánamo doctors) of [Mr. el-Sawah's] respiratory and cardiac conditions rises to the level of neglect.

– Sondra Crosby, MD

Perhaps not surprisingly given the deficiencies and challenges described above, independent civilian medical experts have identified repeated instances where detainees' medical needs have been neglected. For example:

- As noted above, in 2010 Guantánamo medical staff diagnosed Mr. al-Tamir with a serious back condition—spinal stenosis—but did not arrange for surgical intervention until 2018, when Mr. al-Tamir's condition had become so dire that he was at significant risk of paralysis. According to former PHR program director Homer Venters, MD, MS, and PHR Senior Medical Advisor Vincent Iacopino, MD, PhD, who wrote to then Secretary of Defense James Mattis urging immediate treatment for Mr. al-Tamir, "[i]t is common medical knowledge, at the most basic level, that spinal stenosis associated

with increasing motor weakness requires urgent diagnosis and surgical treatment.”⁶⁸

- In the case of Tarek el-Sawah, a detainee who became obese at Guantánamo, Dr. Crosby concluded that notwithstanding an appropriate medication regimen to treat aspects of his condition, “the lack of diagnostic pursuits (despite recommendations by Guantánamo doctors) of his respiratory and cardiac conditions rises to the level of neglect.”⁶⁹ (See Mr. el-Sawah’s case study for further details.)
- In the case of former detainee Mr. Dhiab, Dr. Xenakis—who evaluated Mr. Dhiab and examined his medical records—found that “[t]he living conditions in his cell aggravate his pain and discomfort. Mr. Dhiab sleeps on the metal surface covered by one ISO-MAT [thin sleeping pad] that is inadequate in allowing him to sleep comfortably and does not conform to accepted standards of medical care.”⁷⁰ He further found that “the staff at Guantánamo routinely withheld Dhiab’s crutches and wheelchair and refused to give him basic over-the-counter painkillers.”⁷¹
- Mustafa Ahmed al-Hawsawi sought medical intervention for more than a decade to treat a rectal prolapse caused by his torture in CIA custody, but did not receive the surgery he needed until 2016.⁷² From 2008 until his surgery, Mr. Hawsawi “sat gingerly on a pillow” during military commission hearings due to his rectal prolapse.⁷³

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The inappropriate role of litigation in access to medical care and detainee health

Whether a detainee is being prosecuted before the military commissions or pursuing federal court habeas corpus litigation has a substantial impact—in several ways—on both his access to medical care (including medical records) and the care he receives.

First, unless a detainee is involved in active litigation, it appears to be extremely difficult, if not impossible, for him to access independent civilian medical professionals, and, in some cases, medical records.⁷⁴ For example, after multiple requests for appointment of such an expert, counsel for Mr. al-Libi received the following response from the Convening Authority, the office that oversees the military commissions:

I considered carefully your request ... for Dr. Xenakis to be assigned to Mr. al Libi’s case and to be granted permission to medically evaluate him as a health-care provider. For the reasons set forth below, I am unable to grant your request.

*Under R.M.C. 703(d), I may only appoint experts at government expense to assist the defense in military commissions. There are no charges pending against Mr. al Libi nor, per your request, are you seeking to have Dr. Xenakis aid in your legal representation of Mr. al Libi. Your request seeks to address a medical condition which you believe afflicts Mr. al Libi. Given the circumstances, I may not grant your request.*⁷⁵

Second, for detainees in active federal court habeas corpus litigation, while some judges have granted requests for independent civilian medical experts with more frequency recently, that was not the case for many years, and it remains sporadic.⁷⁶ Moreover, even when the Court does grant such a request, it is limited to the context of a litigation issue. In other words, the independent expert will be appointed, for example, to assess whether a detainee is competent to participate in legal proceedings, or whether his medical condition impedes his ability to communicate with his lawyers. This does not allow for a meaningful and comprehensive assessment of a detainee's health or the care with which he is being provided.

Third, criminal prosecution before the military commissions has, in some cases, exacerbated detainees' medical conditions. For example, the prosecution in Mr. al-Tamir's case has consistently opposed continuances to the litigation schedule based on health concerns. In 2017 he was subjected to a forced cell extraction, despite his previously described chronic and worsening back pain, in order to transport him to a commission proceeding.⁷⁷ In late 2018, Mr. al-Tamir suffered a prolonged back spasm at the beginning of a military commission session. During the next session, the guard force rolled a hospital bed into the courtroom, and, when it was noted that Mr. al-Tamir's pain was increasing, he was administered Valium and forced to nap in the courtroom.⁷⁸ It is clear that shackling, movement, and attendance at commission hearings and at meetings with his attorneys—both required for him to exercise his constitutional rights to be present at the proceedings against him and to counsel—put additional physical strains on his condition.

In the case of Mr. al-Nashiri—whose torture is described in excruciating detail in the declassified executive summary of the Senate Select Committee on Intelligence study of the CIA's former detention and interrogation program—Dr. Crosby has opined that the commission process itself is likely to irreparably harm him:

In my opinion, a capital trial of Mr. Al-Nashiri in the current Military Commission regime will have a profoundly harmful and possibly long lasting effect upon him, in addition to the permanent harm already inflicted. While I would expect a capital trial in any court to be stressful, my knowledge of the more predictable procedures of federal confinement and trials causes me to believe that the contemplated military trial is stressful on a different order of magnitude and, given Mr. Al-Nashiri's situation and fragile psychological state induced by torture, exponentially more harmful.

Indeed, I have serious doubts about Mr. Al-Nashiri's ability to remain physically or mentally capable of handling the physical and emotional stress of the military trial process.⁷⁹

Lastly, military commission prosecutors appear to have access to detainees' medical records—including records to which detainees themselves, or their lawyers, do not, and well beyond that which would be afforded through discovery in an ordinary criminal trial. Such access has led some detainees to refuse medical care for fear that something documented in their medical records will disadvantage them in litigation.

CONCLUSION

The experiences of detainees and independent civilian medical experts with medical care at Guantánamo not only broadly refute the claim that detainees receive care equivalent to that of U.S. service members, but also evidence specific violations of the Mandela Rules, the universally recognized UN standard minimum rules for the treatment of prisoners. The violations include:

- Failure to take, and document, detainees' trauma histories—especially with regard to torture and cruel, inhuman and degrading treatment suffered during U.S. detention and interrogation operations—and corresponding failure to conduct independent investigations into any such allegations (Rules 8, 26, 30, 34, 57);
- Failure to afford medical personnel true clinical independence—including final decision-making authority over decisions that have medical repercussions—and, more generally, to prioritize detainee medical needs over security functions (Rules 25, 27);
- Failure either to ensure consistent prompt access to medical attention in urgent cases or to transfer detainees to the United States for treatment that cannot adequately be provided at Guantánamo (Rule 27);
- Failure to provide detainees with timely and meaningful access to their own medical records (Rules 9, 26, 57);
- Failure to protect confidentiality of detainees' medical records, in particular by allowing broad access to such records by prosecutors (Rules 9; 26, 32);
- Failure to acquire and retain sufficient capability—in either personnel or equipment—to provide appropriate treatment and care, especially but not only for detainees with complex health needs arising from a history of torture and trauma (Rules 25, 27);
- Failure to ensure continuity of treatment and care of detainees due to frequent rotation of military medical personnel (Rule 24);
- Failure to allow those detainees who understandably distrust military medical providers to access independent civilian physicians—or other qualified medical personnel that detainees trust—in a meaningful, ongoing fashion, if at all (Rule 31); and

- Failure to adhere to the prohibition on the use of inherently degrading or painful instruments of restraint, and to limit the use of all forms of restraint to circumstances where there is a legitimate risk of escape, or—after exhausting other less severe forms of control—of a detainee injuring himself or damaging property (Rule 47).

RECOMMENDATIONS

It is not possible to fully resolve all of these serious medical care deficiencies at Guantánamo while the detention facility remains open. For example, effective torture rehabilitation cannot be provided there, and detainees will continue to suffer the profound impact of indefinite detention as long as they remain detained indefinitely. But this fact cannot and must not justify inaction.

Unless and until Guantánamo is closed—which the Center for Victims of Torture and Physicians for Human Rights have long advocated it must be—the U.S. Congress, Judiciary, and Executive Branch can and should take the following steps, respectively, toward closing the gap between the quality of care the United States claims to provide and what is actually happening on the ground at Guantánamo.

For the U.S. Congress:

- 1) Lift the current legislative ban on transferring Guantánamo detainees to the United States, or at minimum create an exception 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.
- 2) Require the Executive Branch to transfer to the United States for medical care any detainee with a medical condition that cannot be evaluated and treated at Guantánamo in a manner 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) Require the Department of Defense to provide, upon a detainee's request—including requests made through a detainee's counsel or other representative with the detainee's consent—timely and meaningful access to all of his own medical records generated or maintained by the Department of Defense and any agency or entity thereof.
- 4) Prohibit the disclosure of detainees' medical records to prosecutors in a military commission or other criminal proceeding without the consent of the detainee, with two exceptions: First, when disclosure is ordered by a military judge or other court of competent jurisdiction after notice to the detainee and the opportunity to be heard, and a finding that the medical records are material to proof of a crime charged in the proceeding; or, second, when disclosure is otherwise authorized by an applicable

statute, regulation, or rule governing discovery in the proceeding.

- 5) Create a new Chief Medical Officer (CMO) to be stationed at Guantánamo and who would oversee the provision of medical care to detainees. The CMO should be a senior, civilian physician charged with ensuring that detainees are provided with 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. This includes ensuring that detainees are not subject to policies or practices that conflict with, undermine, or otherwise negatively impact their health. The CMO should have final decision-making authority over any decision related to medical care for individuals detained at Guantánamo, including, but not limited to, decisions related to assessment, diagnosis, treatment, and medical accommodations to detention conditions of confinement and operating procedures. The CMO should report to a chain of command outside the military and with additional oversight by the independent commission recommended below (Recommendation 7).
- 6) Conduct thorough and regular oversight over medical care at Guantánamo to ensure that detainees are being provided with 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. This should include ensuring that litigation does not negatively impact the medical care with which detainees should be provided or otherwise conflict with their best medical interests.
- 7) Establish an independent commission to assess, report on, and provide further recommendations with respect to the provision of medical care at Guantánamo. The commission should be comprised of independent and senior civilian medical experts, including: an internist with experience in geriatric medicine; an internist with experience in treating victims of torture; a general surgeon with experience in treating victims of torture; a psychologist with experience in treating victims of torture; and a neuropsychiatrist with experience in treating victims of torture and patients with traumatic brain injury. All commission members should be board certified, licensed, and have significant experience working in a cross-cultural setting.

The commission's mandate should include examination of the following issues:

- Whether and how policies, practices, and the command structure at Guantánamo affect medical providers' autonomy and efficacy, decision-making that has medical repercussions, and the medical (including mental health) interests of individuals detained at Guantánamo;

- The ability of military medical providers, in particular but not only Joint Medical Group staff, to develop trusting doctor-patient relationships with individuals detained at Guantánamo;
- The comprehensiveness and accuracy of the medical records of individuals detained at Guantánamo;
- The degree and timeliness of access to detainees' medical records for the detainees themselves; Joint Medical Group, Joint Detention Group and other Joint Task Force Guantánamo staff; outside medical specialists, whether brought in by Joint Task Force Guantánamo or retained by detainees; and government lawyers, detainees' counsel, and judges in both military commissions and federal court proceedings;
- The extent to which medical records of individuals detained at Guantánamo are classified, at what level, and how this impacts access for each of the above stakeholders as well as the provision of medical care to detainees;
- The duration of assignments/rotation schedules (on and off-island) for Joint Medical Group staff, and how those impact the quality of medical care provided to individuals detained at Guantánamo;
- Medical care capability at Guantánamo with respect to both equipment and expertise necessary to 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; and
- For each of the above, whether and how the assessment differs for individuals detained at Guantánamo who are: (i) torture survivors; (ii) being prosecuted before the military commissions, and (iii) pursuing habeas corpus relief in federal court.

The commission should have full access to, and the power to compel, any information that it needs to fulfill its mandate—with detainees' consent where necessary—including both documents and personnel. Where security clearances are necessary, the Executive Branch should be required to facilitate the process expeditiously.

The commission should be mandated to report back to Congress at specified interim periods,

including whenever it deems appropriate. It should also be required to produce a final report with findings and recommendations that include any improvements to be made related to the provision of medical care at Guantánamo going forward, and whether continuing monitoring, assessment, and reporting is advisable following issuance of the final report.

For the U.S. Judiciary and Military Commissions:

- 8) Grant requests for, or order proactively, independent medical evaluations for any detainee who presents with a medical condition or concern about which there is a reasonable question regarding whether he is being provided with medical care 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.
- 9) Require the government to produce expeditiously any medical records that detainees request.
- 10) Prohibit the disclosure of detainees' medical records to prosecutors in a military commission or other criminal proceeding without the consent of the detainee, with two exceptions: First, when disclosure is ordered by a military judge or other court of competent jurisdiction after notice to the detainee and the opportunity to be heard, and a finding that the medical records are material to proof of a crime charged in the proceeding; or, second, when disclosure is otherwise authorized by an applicable statute, regulation, or rule governing discovery in the proceeding.

For the U.S. Executive Branch:

- 11) If Congress lifts the ban on transfers to the United States, even if only for medical purposes, transfer to the United States 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.
- 12) Transfer out of Guantánamo any detainee who, by virtue of his medical circumstances, does not pose a threat to the United States.
- 13) Allow meaningful and regular access to Guantánamo by civilian medical experts, including permitting such experts 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.

- 14) Declassify medical records that have already been classified and discontinue classifying medical records going forward. Legitimate identifiers of government personnel may be redacted in medical records prior to their public release if the government can demonstrate that the redactions meet the requirements of Executive Order 13526.

- 15) Upon a detainee's request, including requests made by counsel with the detainee's consent, provide the detainee with timely and meaningful access to any and all of his own medical records generated or maintained by the Department of Defense, the CIA, and any agency or entity thereof.

CASE STUDIES

Nashwan al-Tamir

We are deeply concerned that the facts of this case do not support DOD’s public claim of appropriate, high quality, and timely medical/surgical care. With all due respect to the medical personnel who traveled on short notice to Guantánamo and performed the therapeutic intervention, especially with Hurricane Irma approaching, this case exemplifies serious problems in the accurate and timely diagnosis of emergency medical/surgical conditions.

– Homer Venters, MD, MS and Vincent Iacopino, MD, PhD (9/8/2017)⁸⁰

Nashwan al-Tamir was captured in Turkey in 2006, rendered to a CIA black site, then transferred to the detention center at Guantánamo Bay, Cuba.⁸¹ As of June 2019, he had been held captive at Guantanamo for 12 years and nine months.

According to portions of Mr. al-Tamir’s medical records, he has been complaining about and seeking treatment for chronic and worsening back pain since he initially entered U.S. custody in 2006. After his arrival at Guantánamo Bay, Mr. al-Tamir informed the detention facility staff that a previous MRI had confirmed that he had a herniated disc. By June 2008 his pain began radiating down his left thigh—a condition that worsened the following year—and he expressed concern about how long it was taking to resolve the issue.

Throughout 2010, Mr. al-Tamir received a variety of treatments—over-the-counter medication (typically BenGay and ibuprofen) and physical therapy—which proved ineffective. In September of that year, he was diagnosed with spinal stenosis after a CT scan. And yet, Mr. al-Tamir would not receive surgical intervention until seven years after his diagnosis. According to doctors Homer Venters, MD, MS, former PHR director of programs, and Vincent Iacopino, MD, PhD, PHR senior medical advisor—both of whom wrote to the defense secretary when they learned about Mr. al-Tamir’s condition in 2017—“[i]t is common

medical knowledge, at the most basic level, that spinal stenosis associated with increasing motor weakness requires urgent diagnosis and surgical treatment."⁸²

From 2011 through 2016, Mr. al-Tamir's symptoms persisted and his health gradually declined. Medical records from this period reflect almost daily complaints regarding serious back pain. He was given some further testing, though the details and scope of any medical assessments remain unclear because neither Mr. al-Tamir nor his counsel have ever been provided with a complete set of his medical records.

On January 9, 2017, during a military commissions proceeding, Mr. al-Tamir was subjected to a forced cell extraction when he refused to be handcuffed by a female guard-force member. A few weeks after this violent incident, Joint Medical Group staff conducted a CT scan that showed further degeneration of his spine and recommended that Mr. al-Tamir undergo an MRI; however, due to the continued unavailability of an MRI machine on-base, that test was not performed. That summer, Mr. al-Tamir began to experience a significant loss of sensation in both of his feet and a loss of bladder control. He was admitted to the Guantánamo base hospital in August 2017. An X-ray and CT scans showed that his back condition had worsened. Although Mr. al-Tamir's condition had not improved, and scheduled attorney-client visits had been cancelled due to his declining medical condition, Guantánamo officials cleared him to attend pretrial hearings held immediately thereafter.

On August 7, 2017, a doctor told Mr. al-Tamir that he needed to see a spinal surgeon, who would arrive in October, but that an injection might mitigate the problem until then. Orthopedic surgeon and PHR Expert James Cobey, MD, MPH, FACS—who reviewed what had been provided of Mr. al-Tamir's medical records—described that plan as follows:

The current treatment plan as reported, consisting of an anesthesiologist visiting in September and a neurosurgeon visiting in October, is unacceptable, inconsistent with the standard of care, and likely to result in permanent neurologic damage. I would not expect a simple epidural injection with steroids to have any real effect on a compression problem. The epidural may temporarily help the foraminal stenosis, but would not help the symptoms of the central stenosis. I urge you in no uncertain terms to take immediate action to effectively diagnose and treat the detainee's medical emergency.⁸³

Contemporaneous records indicate that Guantánamo medical staff failed to treat Mr. al-Tamir's medical status as emergent until early September 2018, after additional correspondence by medical non-profit organizations voiced serious concerns. Shortly thereafter, in an implicit acknowledgement of the crisis it had allowed to befall Mr. al-Tamir, U.S. authorities flew a special medical team to Guantánamo to perform emergency surgery. Over the next eight months, Mr. al-Tamir underwent three additional surgical

procedures on his spine, all performed by surgical teams flown in from the mainland. Correspondence from military medical teams disclosed their fear associated with performing such complicated surgical procedures on-base—one Guantánamo physician wrote to the Base Commander: “The prospect of attempting [the needed surgery] at [US Naval Hospital Guantanamo Bay] scares the hell out of me.”⁸⁴ At least one procedure was devoted exclusively to correcting problems stemming from the placement of hardware in an earlier procedure.

Mr. al-Tamir’s treating neurosurgeon recently testified that, as a result of his quick succession of spinal surgeries, Mr. al-Tamir could suffer from neuropathy, chronic pain, and muscle spasms for the rest of his life. He also testified that Mr. al-Tamir may need additional spinal surgeries in the future, and that certain accommodations should be made by the military commissions and the detention facility staff to avoid “acute exacerbations” of his conditions.

None of this has deterred the military commissions from forging ahead with Mr. al-Tamir’s prosecution. Prosecutors have consistently opposed any continuances to the litigation schedule based on health concerns. In November 2018, Mr. al-Tamir suffered an hour-long back spasm at the beginning of a military commission session. During the next session a few days later, the guard force rolled a hospital bed into the courtroom, and, when it was noted that his pain was increasing, Mr. al-Tamir was administered Valium and forced to nap in the courtroom. His current pain medication regimen relies on the regular administration of opioid pain medication (e.g., Percocet), benzodiazepines (e.g., Valium), and muscle relaxants. All of these medications have a sedating effect, according to his military doctors.

According to press reports from January 2019, the Defense Department is shipping a large, handicapped-accessible cell to Guantánamo so that Mr. al-Tamir could “live at the court” during proceedings while continuing to recover from his surgeries.⁸⁵ The cell was supposed to be operational by March, but was not. Instead, the detention facility provided what Mr. al-Tamir’s counsel described as an uninhabitable substitute that fell far short of the medical accommodations promised.

Sharqawi Al Hajj

The government appears to discount legitimate concern about Mr. Al Hajj's health because it states that Mr. Al Hajj's symptoms are explained by a benign liver condition ... and that he is not suffering from other potentially serious underlying illnesses. It fails to address the effects of the symptoms themselves, whatever their source.

...

My familiarity with the medical facilities at Guantánamo also raises concern that in the midst of a true emergency, Guantánamo Bay's medical facilities would not be equipped to provide the necessary medical care to Mr. Al Hajj, including the availability of an MRI for diagnostic procedures and advanced surgical equipment and personnel.

– Jess Ghannam, MD (9/26/2017)⁸⁶

Mr. Sharqawi Al Hajj is a 43-year-old citizen of Yemen. He was taken into custody by U.S. and Pakistani forces in February 2002 then rendered to Jordan, where for nearly two years he was detained—hidden from the International Committee of the Red Cross—and tortured, including through extensive beatings on his feet and threats of electrocution and sexual abuse.⁸⁷ He was then rendered to a CIA black site prison in Afghanistan “where he ‘was kept in complete darkness and subjected to continuous loud music’” until his transfer in 2004 to the detention center at Guantánamo Bay, Cuba.⁸⁸ As of June 2019, Mr. Al Hajj had been held captive there for 14 years and nine months.

In July 2017, after several weeks of a hunger strike because of increasing despair over his poor health and indefinite detention, Mr. Al Hajj fell unconscious and required emergency hospitalization. Shortly thereafter, he brought an emergency motion for an independent medical evaluation and production of his medical records.⁸⁹ The government opposed both requests and, as of June 2019, the court had not ruled.

Mr. Al Hajj's longstanding health problems include profound weakness and fatigue, recurrent jaundice, severe abdominal pain, difficult painful urination, and constipation. He was also diagnosed with Hepatitis

B prior to his detention at Guantánamo. In the months leading up to September 2017, Mr. Al Hajj's counsel noticed his health declining appreciably: "He appeared frail, gaunt, and had noticeable difficulty maintaining energy and concentration."⁹⁰

Medical providers at Guantánamo conducted multiple ultrasounds and CT scans on Mr. Al Hajj, and he was evaluated several times by a gastroenterologist who performed an endoscope examination and a colonoscopy. Based on the results, Guantánamo medical staff diagnosed Mr. Al Hajj with Gilbert's Syndrome ("a benign congenital condition") and a hereditary enzyme deficiency, neither of which, they determined, required treatment. Instead, medical staff concluded that Mr. Al Hajj's pain and suffering were a result of his hunger strike, and that his "life and health are not in jeopardy."⁹¹

Mr. Al Hajj's counsel retained two outside medical experts, including Dr. Jess Ghannam, to evaluate Mr. Al Hajj's health circumstances to the extent possible in light of the government's refusals to turn over Mr. Al Hajj's medical records or to allow for an independent medical evaluation. Notwithstanding these limitations, several of Dr. Ghannam's findings bear mention:

- The gastro-intestinal difficulties, chronic pain, fatigue, and general physical impairment Mr. Al Hajj is experiencing he reported before his hunger strike began, and those symptoms "can cause severe physical and neuropsychological damage if they persist."⁹² In the midst of a hunger strike "they can lead to medically irreparable harm if not properly diagnosed and treated."⁹³
- Mr. Al Hajj repeatedly voiced distrust of Guantánamo medical care providers, "which is a subjective experience and separate from the quality of the care that may be being offered, and can persist even if he accepts offered medical care." This led Dr. Ghannam "to question the reliability of the assessments about Mr. Al Hajj's condition. Trust in one's doctor is a necessary precondition to being forthcoming with information and consenting to care, which are in turn essential to making an accurate diagnosis and prognosis and providing effective treatment. It is problematic, if not impossible, for the standard doctor-patient relationship to develop at Guantánamo, thereby weakening the foundation of the standard practice of medicine—the establishment of trust in one's doctor. All personnel in Guantánamo, including medical staff, are perceived and experienced as part of the detainee's original torture project. In my experience, the possibility of developing trust in a doctor is virtually impossible for Guantánamo detainees and, as a result, it is not possible to comfortably rely on the [senior medical officer's] assurance that Mr. Al Hajj is 'in good health.'"⁹⁴
- "In my experience in other Guantánamo detainee cases, it is not uncommon for detainees

complaining of ailments to be characterized as stable despite serious concerns and in some cases the need ultimately for emergency care."⁹⁵

- "Access to one's personal medical information is a basic right recognized in medical policy guidelines. Having access to Mr. Al Hajj's medical records would provide important insight into his condition and allow for further preventive steps to avoid the possibility of irreparable medical harm that he faces.... His complete medical records, in conjunction with an independent medical evaluation with a doctor with whom trust could be established, is the only reasonable standard to truly assess if Mr. Al Hajj is 'in good health' and provide basic and adequate health care that would prevent irreparable harm to his already fragile condition."⁹⁶

On October 26, 2018, counsel for Mr. Al Hajj reported that his "health continues to be in jeopardy. He continues to engage in prolonged hunger strikes as a desperate response to his ill health and inadequate health care; his protests further aggravate his health concerns; and his worsened condition leads to greater distress and more extreme protests." Counsel was especially concerned with an apparent decline in Mr. Al Hajj's mental health, given that Mr. Al Hajj "refuses mental health care at Guantánamo for lack of trust."⁹⁷ Counsel alerted Guantánamo officials and the Justice Department directly to her concern and, as of June 2019, had received no response.

Tarek el-Sawah

It is my strong conclusion that Mr. El-Sawah is in extremely poor health and requires timely medical evaluation and treatment for multiple serious medical conditions. I am alarmed that since my initial evaluation in 2011, appropriate testing and treatment has not occurred. This failure of treatment is despite multiple and repeated recommendations from military physicians, whose opinions and recommendations are generally in agreement with my own. Because of the failure of Guantánamo officials to comply with medical recommendations that would meet basic standards of care, Mr. El-Sawah's health has markedly deteriorated.

– Sondra Crosby, MD (9/3/2013)⁹⁸

Tarek El-Sawah was arrested by the Northern Alliance in Afghanistan then turned over to U.S. forces in December 2001. He was sent to the detention center at Guantánamo Bay, Cuba in May 2002. In September 2008, the Bush administration recommended he be transferred out of Guantánamo. On January 20, 2016, he was transferred to Bosnia and Herzegovina.

When he arrived at Guantánamo, Mr. el-Sawah (who is five feet, ten inches tall) weighed approximately 215 pounds.⁹⁹ By August 2013—as a result of interrogators exploiting an eating disorder by offering him excessive amounts of food in exchange for information¹⁰⁰—he weighed over 400 pounds and suffered from “multiple serious life threatening medical co-morbidities” such that he was at “significant increased risk of mortality.”¹⁰¹ His counsel, to whom the government had refused to provide any medical records over the course of the two previous years, filed a motion in Mr. el-Sawah’s habeas case for emergency medical care.¹⁰²

The government responded that Mr. el-Sawah was being afforded sufficient medical care, but to the extent there were tests and treatment that he did not receive it was because “he refuses medical treatment on a regular basis.”¹⁰³ Mr. el-Sawah disagreed with that characterization; what he refused

was having his legs and hands shackled for transport to medical appointments pursuant to a newly instituted policy.¹⁰⁴ The government disputed that leg shackling was required (at least prospectively)¹⁰⁵ and stated that “nothing medically prohibits” hand shackling Mr. el-Sawah.¹⁰⁶ More generally—on the basis of a declaration submitted by a doctor from the Joint Medical Group who reviewed Mr. el-Sawah’s medical records but who did not attest to having personally examined him—the government claimed that Mr. el-Sawah’s “life is not in imminent danger, nor is he in immediate danger of losing his ability to communicate with others.”¹⁰⁷

Two independent medical experts, Sondra Crosby, MD and Brigadier General (Ret) Stephen Xenakis, MD, medical experts for Physicians for Human Rights, were allowed to examine Mr. el-Sawah and review the portions of his medical records that his counsel was able to obtain, both before and after the filing of the emergency motion. Dr. Crosby evaluated him in March 2011 and March 2012, and visited with him briefly in July 2013. She again evaluated him and performed a brief physical examination on November 14, 2013. Dr. Xenakis conducted a two-hour medical interview with Mr. el-Sawah on August 13, 2013 and joined Dr. Crosby for the 2012 evaluation.

Both doctors found failures to meet the basic standard of medical care. Although the government’s attention to Mr. el-Sawah’s condition improved markedly following the filing of the emergency motion,¹⁰⁸ in some cases failures persisted. Doctors Crosby and Xenakis attribute failures to meet the basic standard of care to various combinations of the following: proper diagnoses and recommendations but lack of equipment or expertise to perform the necessary tests; improper or incomplete evaluation and treatment; unrealistic policies that interfered with Mr. el-Sawah receiving appropriate medical care; and neglect. For example:¹⁰⁹

- Based on what Mr. el-Sawah told Dr. Xenakis, “the authorities at JTF-GTMO are obstructing appropriate medical testing and treatment. They have imposed unrealistic and harmful conditions for his movement from confinement to the medical clinic that prevent him from receiving appropriate medical care. These policies and practices violate the accepted procedures of medical care in a military setting.”¹¹⁰
- In September 2012, “a military otolaryngologist opined that Mr. el-Sawah’s symptoms were consistent with sleep apnea and that polysomnography would be required for diagnosis, but noted that Guantánamo does not have this capacity,” and so “treatment would be continuous positive airway pressure (CPAP).” According to the government, as of early September 2013, the CPAP machine had not yet arrived.
- As of September 3, 2013, Mr. el-Sawah had “not undergone pulmonary evaluation that would

meet even minimum standards of care to address his progressive pulmonary disease.”

- “In addition to pulmonary disease, Mr. el-Sawah is at a very high risk for coronary artery disease (‘CAD’).” He describes “symptoms that are highly suspicious for cardiac disease given his multiple risk factors.” A military cardiologist who examined Mr. el-Sawah on December 12, 2012 concluded the same, “but noted that ‘patient’s weight exceeds any available means to test for CAD at GTMO.’ On June 4, 2013, a follow up cardiac consultation also concluded that Mr. el-Sawah’s ‘weight limits current testing at NH GTMO.’”
- The government states that “Mr. el-Sawah has ‘refused’ an echocardiogram. However, an echocardiogram is of limited use for a patient of Mr. el-Sawah’s size and would not evaluate myocardial ischemia or determine if there is blockage in his arteries. In fact, Mr. el-Sawah underwent an echocardiogram in Guantánamo in 2007 ... and his size prohibited the technicians from seeing anything useful to determine the status of his heart condition.”
- As of September 3, 2013, Dr. Crosby agreed with Guantánamo medical authorities’ “medication regimen to aggressively treat Mr. El-Sawah’s lipids, blood pressure, diabetes and anticoagulation for stroke prevention. However, the lack of diagnostic pursuits (despite recommendations by Guantánamo doctors) of his respiratory and cardiac conditions rises to the level of neglect.”
- With regard to Mr. el-Sawah’s obesity, the government stated that “‘Petitioner has been advised on numerous occasions to consume fewer calories and get regular exercise.’ This is not the standard of care for someone in Mr. el-Sawah’s weight range, which is stated to be 408 pounds.”
- “Given Mr. El-Sawah’s ongoing undiagnosed symptoms of chest pain and shortness of breath, encouraging regular exercise is reckless and could prove dangerous prior to further evaluation and treatment. Medical practice guidelines (including those published by the National Institutes of Health) dictate that a patient in Mr. El-Sawah’s current condition undergoes evaluation and treatment from a physician with expertise in the treatment of obesity.”

Abd al-Rahim al-Nashiri

Mr. Al-Nashiri is most likely irreversibly damaged by torture that was unusually cruel and designed to break him... Making matters worse, there is no present effort to treat the damage, and there appear to be efforts to block others from giving him appropriate clinical care.

...

His deterioration is exacerbated by the lack of appropriate mental health treatment at Guantánamo. Based on my assessment and vast experience caring for survivors of torture, the physical and mental health care afforded to him is woefully inadequate to his medical needs. A significant factor in my opinion is that medical professionals, including mental health care providers, have apparently been directly or indirectly instructed not to inquire into the causes of Mr. Al-Nashiri's mental distress, and as a consequence, he remains misdiagnosed and untreated.

– Sondra Crosby, MD (10/14/2015)¹¹¹

Abd al-Rahim al-Nashiri, a national of Saudi Arabia, was captured by local authorities in Dubai in October 2002. After being transferred to U.S. custody he was rendered to a series of CIA “black site” prisons before being sent, in 2006, to the detention center at Guantánamo Bay, Cuba. As of June 2019, Mr. al-Nashiri had been held captive there for 12 years and two months.

During his time in CIA custody, Mr. al-Nashiri was tortured frequently and extensively. The abuses to which he was subjected include, but are not limited to: forced nudity, “stress positions,” being shackled to the ceiling or to walls for long periods in a freezing cold cell, waterboarding, “rectal feeding” (which is rape by object under the Uniform Code of Military Justice), mock execution with both a handgun and a power drill, threats to his family, and “forced bathing” with a stiff brush to abrade his skin.¹¹² In describing detainees at one of the black sites at which Mr. al-Nashiri was held, a CIA interrogator said “[they] literally looked like [dogs] that had been kenneled.’ When the doors to their cells were opened, ‘they cowered.’”¹¹³

In March of 2012, Dr. Sondra Crosby was appointed by the Defense Department as an expert in the field of internal medicine and the treatment of torture victims to conduct an evaluation of Mr. al-Nashiri's physical and mental condition. After reviewing both classified and unclassified records and examining/observing Mr. al-Nashiri for approximately 30 hours, she concluded: "in my many years of experience treating torture victims from around the world, Mr. Al-Nashiri presents as one of the most severely traumatized individuals I have ever seen."¹¹⁴

In early 2013, the government requested that a competency board evaluate Mr. al-Nashiri. "Two psychologists and one psychiatrist [from Walter Reed Military Medical Center] conducted interviews with [him] and reviewed numerous documents including summaries of his interrogations, medical assessment notes, and psychological assessment notes from 2002 through 2006.' They concluded that he suffers from post-traumatic stress disorder (PTSD) and major depressive disorder."¹¹⁵ To that point, no Guantánamo doctor had ever reached the same conclusion.

In March of 2014, Dr. Crosby was called to testify as an expert witness at a hearing in Mr. al-Nashiri's case arising out of her opinion that conditions of his confinement were triggering past traumatic experiences. Both her testimony and that of Mr. al-Nashiri's then-most recent treating psychiatrist at Guantánamo (referred to as "Dr. 97") revealed a number of serious concerns with the medical care he had been receiving.

Most glaring was an absence of a trauma history in any of Mr. al-Nashiri's Guantánamo medical records. According to Dr. 97, who had been board certified in psychiatry for less than two years, "nowhere in Mr. Nashiri's psychiatric records compiled at Guantánamo from 2006 to 2014 is there a detailed account of what ... he went through prior to coming to Guantánamo[.]"¹¹⁶ Dr. 97 testified that he had "suspicions," but did not "know factually where [Mr. al-Nashiri] was or with whom he was." Rather than ask Mr. al-Nashiri what happened to him, Dr. 97 said that he "assumed" Mr. al-Nashiri had serious trauma but did not "know factually the details."¹¹⁷

Dr. Crosby confirmed that she had not seen a trauma history in any of the Guantánamo-generated records that she reviewed. And because of that omission, Mr. al-Nashiri "was not diagnosed correctly and is not receiving the proper treatment."¹¹⁸ Specifically, Dr. Crosby concluded that "Mr. [al-]Nashiri suffers from [PTSD] that has not been addressed."¹¹⁹

In March of 2013, shortly after the competency board diagnosed PTSD, a Guantánamo doctor added that same diagnosis to Mr. al-Nashiri's medical records for the first time. Various military mental health professionals carried forward the PTSD diagnosis throughout 2013, but there was never a foundation

laid for it. In other words, there was no documentation that a health professional had ever conducted a diagnostic evaluation—actually gone through the diagnostic criteria—for PTSD. “You cannot diagnose somebody with post-traumatic stress disorder unless you have a trauma, a significant trauma,” Dr. Crosby explained, “and there’s no such history in the record.”¹²⁰

For years, Guantánamo medical staff had been “treat[ing] the symptoms ... without treating the cause.”¹²¹ Not only was that approach ineffective, but also it harmed Mr. al-Nashiri in concrete ways. For example, at times Mr. al-Nashiri refused to see treatment providers because doing so required him to wear a “belly chain.”¹²² Given that flashbacks (i.e. a past traumatic experience recurring vividly in the mind) are a common symptom of PTSD, if one understands what Mr. al-Nashiri suffered it is not difficult to appreciate his objection. That understanding would also facilitate identifying an appropriate solution.

On March 12, 2014—again, without taking Mr. al-Nashiri’s trauma history—Dr. 97 changed Mr. al-Nashiri’s conclusory PTSD diagnosis to one of narcissistic personality disorder.¹²³ The change is troublesome both substantively and for its timing. With regard to the former, according to Dr. Crosby, Mr. al-Nashiri’s medical records are replete with red flags for PTSD: “He suffers from chronic pain. He suffers from anal-rectal complaints ... Multiple other physical complaints, headaches, chest pain, joint pain, stomach pain. These are all symptoms that are highly prevalent in people who have suffered torture and [] have chronic PTSD.”¹²⁴ She is confident in her assessment that Mr. al-Nashiri does not have narcissistic personality disorder.

As to timing, Dr. 97 changed the diagnosis in the few weeks after learning that Dr. Crosby would be testifying to medical concerns she had with Mr. al-Nashiri’s treatment, and after discussing with the prosecution and the senior medical officer that she would be evaluating Mr. al-Nashiri using the Istanbul Protocol—the international standard for the investigation and documentation of torture—with which Dr. 97 was not previously familiar.¹²⁵

ENDNOTES

- ¹ As of June 2019, military commission prosecutors were pursuing charges against three additional detainees but the office overseeing the commissions—the Convening Authority—had not yet approved the charges.
- ² Carol Rosenberg, *Guantanamo Bay as Nursing Home: Military Envisions Hospice Care as Terrorism Suspects Age*, NY Times, April 27, 2019, available at <https://www.nytimes.com/2019/04/27/us/politics/guantanamo-bay-aging-terrorism-suspects-medical-care.html>.
- ³ 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.
- ⁴ *Id.*
- ⁵ This includes, but is not limited to, detainees who were tortured or otherwise abused as part of the CIA's former rendition, detention and interrogation program.
- ⁶ Laurel Fletcher and Eric Stover, *Guantanamo and its Aftermath: U.S. Detention and Interrogation Practices and Their Impact on Former Detainees* at 52 (Nov. 2008), available at https://www.law.berkeley.edu/files/IHRLC/Guantanamo_and_Its_Aftermath.pdf.
- ⁷ *US v. Hadi al-Iraqi*, AE099RR at 2-3.
- ⁸ *Boumediene v. Bush*, 553 U.S. 723 (2008).
- ⁹ *Hamdi v. Rumsfeld*, 542 U.S. 507 (2004); *Al-Alwi v. Trump*, No. 18-740 (Sup. Ct. June 10, 2019) (Denying pet. for writ of cert., statement of Breyer, J.)
- ¹⁰ *Ali v. Trump*, No. 17-5067 (D.C. Cir. Aug. 7, 2018) (Denying hearing en banc).
- ¹¹ Kathleen T. Rhem, *Guantanamo Detainees Receiving 'First-Rate' Medical Care*, U.S. Department of Defense News, Feb. 18, 2005, available at <https://archive.defense.gov/news/newsarticle.aspx?id=25852>.
- ¹² U.S. Army Regulation 190-8, *Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees*, available at <https://info.publicintelligence.net/USArmy-Detainees.pdf>.
- ¹³ *Id.* at 3-4(e).
- ¹⁴ *Id.* at 6-6(c).
- ¹⁵ See, e.g., David Fathi, Director, ACLU National Prison Project, *Victory! UN Crime Commission Approves Mandela*

Rules on Treatment of Prisoners, available at <https://www.aclu.org/blog/prisoners-rights/solitary-confinement/victory-un-crime-commission-approves-mandela-rules> ("One notable feature of this year's Crime Commission was the positive role played by the United States. The U.S. delegation strongly supported adopting the rules and naming them in honor of Nelson Mandela, whom it called "one of the greatest defenders of human rights and dignity in recent history." It resisted attempts to reopen the text of the Mandela Rules that had been agreed to in Cape Town earlier this year, and it fought back against efforts to insert language that would allow countries to disregard certain rules for cultural and religious reasons."); ACLU Statement at the High Level Presentation of the Nelson Mandela Rules UN General Assembly, New York, October 7, 2015 ("We also wish to specifically thank the U.S. government for championing the Mandela Rules and making commitments to implement them at home and abroad."), available at <https://www.aclu.org/other/aclu-statement-high-level-presentation-nelson-mandela-rules>; Dan Sicorsky, *The Nelson Mandela Rules: Honoring a Prisoner Turned World Leader*, DIPNOTE, U.S. Department of State Official Blog, July 18, 2017, available at <https://blogs.state.gov/stories/2017/07/18/en/nelson-mandela-rules-honoring-prisoner-turned-world-leader>.

- ¹⁶ United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), General Assembly resolution A/RES/70/175 (17 December 2015), available at <https://undocs.org/A/RES/70/175>.
- ¹⁷ Numerous United Nations Rapporteurs have confirmed that the Mandela Rules are applicable at Guantanamo. See, e.g., *"It's not just about closing Guantánamo, but also ensuring accountability, UN rights experts say,"* United Nations Office of the High Commissioner for Human Rights News, Geneva (26 February 2016) ("Any detainees must be held under the conditions that respect international standards,' they stated, 'including those under international humanitarian law and the Mandela Rules—the Revised UN Standard Minimum Rules for the Treatment of Prisoners (SMRs).' The experts: Mr. Ben Emmerson, UN Special Rapporteur on human rights and counterterrorism; Mr. Juan E. Méndez, UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; Ms. Mónica Pinto, UN Special Rapporteur on independence of the judiciary; Mr. Seong-Phil Hong, Chair-Rapporteur of the UN Working Group on Arbitrary Detention; Ms. Houria Es-Slami, Chair-Rapporteur of the Working Group on Enforced or Involuntary Disappearances; and Mr. Alfred De Zayas, UN Independent Expert on the promotion of a democratic and equitable international order."), available at <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=17097&LangID=E>.
- ¹⁸ Brief for the Center for Victims of Torture as Amicus Curiae at 7-10, *Al Bihani et al. v. Trump*, 09-cv-00745-RCL (D.D.C., January 24, 2018) ("CVT Guantanamo Amicus Brief"), available at <https://www.cvt.org/sites/default/files/Final%20Amicus%20Brief-4.Jan%202018.pdf>; Physicians for Human Rights, *Punishment Before Justice: Indefinite Detention in the U.S.* 2 (2011) ("*Punishment Before Justice*"), available at https://s3.amazonaws.com/PHR_Reports/indefinite-detention-june2011.pdf; Physicians for Human Rights, *Broken Laws, Broken Lives: Medical Evidence of Torture by U.S. Personnel and Its Impact* 75 (2008), available at <http://physiciansforhumanrights.org/library/reports/broken-laws-torture-report-2008.html>.

- ¹⁹ Camp Delta Standard Operating Procedures, Joint Task Force—Guantanamo (JTF-GTMO), Guantanamo Bay, Cuba, March 1, 2004 at 19.7, available at http://hrlibrary.umn.edu/OathBetrayed/sop_2004.pdf. It is unclear whether this SOP remains in effect.
- ²⁰ *Id.* at 19.6.
- ²¹ Emergency Motion for Preliminary Injunction for Proper Medical Treatment, *Paracha v. Bush*, No. 04-CV-2022 (D.D.C. Nov. 22, 2006) (affidavit of Zachary Katznelson).
- ²² Dr. [REDACTED], Evaluation and opinion regarding Ghaleb Nasser Al-Bihani, April 8, 2014 at 3-4 (“Al-Bihani PRB Eval.”) available at https://www.prs.mil/Portals/60/Documents/ISN128/140408_ISN128_U_DETAINEE’S_WRITTEN_SUBMISSION_PUBLIC.pdf?ver=2014-07-03-120331-410.
- ²³ Expert Report of Stephen N. Xenakis, MD, *Dhiab v. Obama*, Civ. No. 05-1457 (GK) (D.D.C. Sept. 15, 2014) (“Xenakis Dhiab Eval.”).
- ²⁴ See Mr. al-Tamir’s case study *infra*.
- ²⁵ *US v. Hadi al-Iraqi*, AE099OO, Attachment B (Decl. of Senior Medical Officer) at ¶ 9; *US v. Hadi al-Iraqi*, AE099SS, Attachment B (Decl. of Senior Medical Officer) at ¶ 8; *US v. Hadi al-Iraqi*, AE099QQ, Attachment B (Decl. of Senior Medical Officer) at ¶ 9.
- ²⁶ *US v. Hadi al-Iraqi*, 13 Feb transcript at 1940-41, 1935.
- ²⁷ *US v. Hadi al-Iraqi*, AE099RR at 2-3.
- ²⁸ Decl. of Dr. Sondra S. Crosby in support of Petitioner Tariq Ba Odah’s Motion for Habeas Relief, *Ba Odah v. Obama*, Civil Action No. 06-1668 (TFH) (D.D.C. June 22, 2015) (“Crosby Ba Odah Decl.”) (“A trust-based doctor-patient relationship is of paramount importance for treatment and recovery.”); Reply in Support of Petitioner’s Emergency Motion for an Independent Medical Evaluation and Medical Records, Ex. 1, Supp. Decl. of Dr. Jess Ghannam, dated Sept. 26, 2017, at ¶ 6, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. Sept. 27, 2017) (“Ghannam Supp. Al Hajj Decl.”) (“[T]rust in one’s doctor is a necessary precondition to being forthcoming with information and consenting to care, which are in turn essential to making an accurate diagnosis and prognosis and providing effective treatment.”).
- ²⁹ Ghannam Supp. Al Hajj Decl., *supra* note 28, at ¶ 6.
- ³⁰ Dr. Ghannam’s experience—and that of other independent medical experts (including the International Committee of the Red Cross)—is that “it is problematic, if not impossible, for the standard doctor-patient relationship to develop at Guantanamo...” Ghannam Supp. Al Hajj Decl., *supra* note 28, at ¶ 6; See also, e.g., Neil A. Lewis, *Red Cross Finds Detainee Abuse in Guantánamo*, *New York Times* (Nov. 30, 2004), available at <http://>
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www.nytimes.com/2004/11/30/politics/30gitmo.html?pagewanted=1&_r=0 ("The [ICRC] report said that such 'apparent integration of access to medical care within the system of coercion' meant that inmates were not cooperating with doctors. Inmates learn from their interrogators that they have knowledge of their medical histories and the result is that the prisoners no longer trust the doctors.").

- ³¹ Senate Armed Services Committee, *Inquiry Into the Treatment of Detainees in U.S. Custody* (2008) at xx, xiii, 103-104, 132-145, available at <https://www.armed-services.senate.gov/imo/media/doc/Detainee-Report-Final-April-22-2009.pdf> ("SASC Report").
- ³² See, e.g., *id.* at 38, 39; 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://detaineeetaskforce.org/pdf/Chapter-6_Role-of-Medical-Professionals.pdf.
- ³³ *Id.*
- ³⁴ 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.").
- ³⁵ 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.").
- ³⁶ Detention Medical Interface with Behavioral Science Consultation Team at 1 (February 15, 2005) ("The Behavioral Science Consultation Team (BSCT) is NOT part of the Joint Task Force Guantanamo (JTF-GTMO), Joint Medical Group (JMG). They are a component of the Joint Interrogation Group (JIG) that supports the Interrogation Control Element (ICE) and Joint Detention Operations Group (JDOG)").
- ³⁷ Sheri Fink, *Where Even Nightmares Are Classified: Psychiatric Care at Guantanamo*, NY Times, Nov. 12, 2016, available at <https://www.nytimes.com/2016/11/13/world/guantanamo-bay-doctors-abuse.html> ("If you complain about your weak point to a doctor," one former detainee explained, "they told that to the interrogators.").
- ³⁸ Al-Bihani PRB Eval., *supra* note 22.
- ³⁹ Dr. Emily Keram, Evaluation of Mohammed al Qahtani, June 5, 2016 ("al Qahtani PRB Eval."), available at <https://>
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www.prs.mil/Portals/60/Documents/ISN063/160606_U_ISN063_DETAINEE_SUBMISSION_PUBLIC2.pdf.

- ⁴⁰ Petitioner's Motion for a Status Conference, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. October 26, 2018).
- ⁴¹ Carol Rosenberg, *For aging Guantanamo captives, a cardiac care lab*, Miami Herald, Sept. 28, 2012, available at <https://www.miamiherald.com/news/nation-world/world/americas/guantanamo/article1943141.html>.
- ⁴² Respondent's Opposition to Petitioner's Motion to Reinstate His Habeas Petition and for Judgment on the Record, *Ba Odah v. Obama*, Civil Action No. 06-1668 (TFH) (D.D.C. Aug. 14, 2015), Ex. 1, Declaration of Commander [REDACTED] dated July 30, 2015 at ¶ 20, 16.
- ⁴³ Supplemental Decl. of Dr. Jess Ghannam in Further Support of Petitioner Tariq Ba Odah's Motion for Habeas Relief at ¶ 3, *Ba Odah v. Obama*, Civil Action No. 06-1668 (TFH) (D.D.C. Sept. 9, 2015).
- ⁴⁴ *Id.* at ¶ 15.
- ⁴⁵ Supplemental Decl. of Dr. Sondra S. Crosby in support of Petitioner Tariq Ba Odah's Motion for Habeas Relief at ¶ 18, *Ba Odah v. Obama*, Civil Action No. 06-1668 (TFH) (D.D.C. Sept. 10, 2015) ("Crosby Supp. Ba Odah Decl.").
- ⁴⁶ *Id.* at ¶ 2.
- ⁴⁷ Supplemental Decl. of Dr. Rami Bailony in support of Petitioner Tariq Ba Odah's Motion for Habeas Relief at ¶¶ 5-6, *Ba Odah v. Obama*, Civil Action No. 06-1668 (TFH) (D.D.C. Sept. 9, 2015).
- ⁴⁸ Petitioner's Emergency Motion for an Independent Medical Evaluation and Medical Records, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. Sept. 6, 2017), Ex. C, Decl. of Dr. Jess Ghannam, dated Aug. 29, 2017 ("Ghannam Al Hajj Decl.") at ¶ 6; Al-Bihani PRB Eval., *supra* note 22, at 4; al Qahtani PRB Eval., *supra* note 39, at 9.
- ⁴⁹ Al-Bihani PRB Eval., *supra* note 22, at 4.
- ⁵⁰ Vincent Iacopino, MD, PHD and Brigadier General (Ret) Stephen N. Xenakis, MD, *Neglect of medical evidence of torture in Guantánamo Bay: a case series*, PLOS Medicine, April 26, 2011.
- ⁵¹ CVT Guantanamo Amicus Brief, *supra* note 18, at 18 (citing Fink, *supra* note 37).
- ⁵² Declaration of Dr. Sondra S. Crosby (Oct. 24, 2015) at ¶ 12, available at https://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/USA/INT_CAT_ICA_USA_24558_O.pdf ("Crosby Al-Nashiri Decl.").
- ⁵³ Ghannam Supp. Al Hajj Decl., *supra* note 28, at ¶ 11; *see also* The Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, 45 CFR § 164.524 (Access of Individuals to Protected Health Information); United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), General Assembly resolution A/RES/70/175 (17 December 2015), Rules 9, 26, and 57, available at <https://undocs.org/A/RES/70/175>.

- ⁵⁴ Petitioner's Emergency Motion for Medical Care, Attachment 2, Decl. of Sean M. Gleason dated August 21, 2013, *Alsawam v. Obama*, Case No. 05-cv-1244 (CKK) (D.D.C. Aug. 21, 2013) ("Gleason Decl.").
- ⁵⁵ Government's Opposition to Petitioner's Emergency Motion for an Independent Medical Evaluation and Medical Records at 2, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. Nov. 27, 2017).
- ⁵⁶ Dr. Jess Ghannam, evaluation of Mr. Mustafa Muhammad Abu Faraj al-Libi, March 12, 2016 ("Ghannam al-Libi Eval.").
- ⁵⁷ See, e.g., Joe Margulies, *Gina Haspel, Trump's Pick for CIA Director, Ran the Prison Where My Client Was Tortured. I Have Questions for Her*, Time.com, March 14, 2018, available at <http://time.com/5199408/abu-zubaydah-lawyer-gina-haspel/> ("Because of what he was made to endure, Abu Zubaydah suffers from frequent seizures, the origin of which cannot be determined. He is tormented by sounds that others do not hear, and cannot remember simple things that others cannot forget. Because his condition is classified, there is much about his welfare that the United States will not let me say. They have authorized me to report, however, that I am "very concerned" about his health."); Jessica Schulberg, *Pentagon Accused Of Denying Medical Care To Torture Victim And Alleged 9/11 Plotter*, Huffington Post, Feb. 11, 2016, available at https://www.huffpost.com/entry/mustafa-al-hawsawi-torture-guantanamo-medical-treatment_n_56bcec2de4b0c3c55050885a ("Further complicating al Hawsawi's medical treatment is the classification of much of his medical records. Navy Cmdr. Walter Ruiz, who represents al Hawsawi, says that the records his team does get access to are incomplete, provided on a sixth-month delay and are partially redacted.").
- ⁵⁸ Executive Order 13526 § 1.1.
- ⁵⁹ To the extent that classification of medical records is about identifying government personnel and the government maintains that such redactions are necessary, it should not be difficult to redact those identifiers in a timely fashion.
- ⁶⁰ See, e.g., CVT Guantanamo Amicus Brief, *supra* note 18, at 7-10; *Punishment Before Justice*, *supra* note 18, at 2.
- ⁶¹ See, e.g., Petitioner's Notice of Filing of Expert Report of Dr. Sondra Crosby, MD, *Dhiab v. Obama*, Civ. No. 05-1457 (GK) (D.D.C. Sept. 9, 2014) ("In addition, based on my interview and review of the medical record, the medical staff is not appropriately equipped to understand or treat the cultural aspects of Mr. Dhiab's medical condition, causing further alienation."); al Qahtani PRB Eval., *supra* note 39.
- ⁶² CVT Guantanamo Amicus Brief, *supra* note 18, at 11-19 (citing CVT's Director of Client Services, Dr. Andrea Northwood).
- ⁶³ See, e.g., case study of Nashwan al-Tamir, *infra*.
- ⁶⁴ Ghannam Al Hajj Decl., *supra* note 48, at ¶ 7.

- ⁶⁵ See, e.g., case study of Tarek El Sawah, *infra*.
- ⁶⁶ Xenakis Dhiab Eval., *supra* note 23.
- ⁶⁷ See, e.g., Letter from Sondra S. Crosby, MD and Brigadier General (Ret) Stephen N. Xenakis, MD, to Members of the United States Senate, Nov. 19, 2013, available at <https://constitutionproject.org/wp-content/uploads/2013/11/Crosby-Xenakis-Medical-Transfer-Letter.pdf> (“Adnan Farhan Abdul Latif died at Guantanamo by alleged suicide in September 2012, years after he had been cleared for transfer. Mr. Latif was seriously mentally ill and suffered from traumatic brain injury. A report by U.S. Southern Command cited lapses in procedures as contributory to his death, and depicts woefully substandard medical care. Mr. Latif required tertiary neuropsychiatric care that was not available at Guantanamo, and it is possible he would be alive if he had had access to the proper care); see also case studies of Nashwan al-Tamir and Tarek El Sawah, *infra*; CVT Guantanamo Amicus Brief, *supra* note 18, at 7-10.
- ⁶⁸ Amended Petition for Habeas Corpus, *al-Iraqi v. Trump*, Case No. 17-cv-1928 (EGS) (D.D.C. Nov. 1, 2017) (“al-Tamir Amended Habeas”), Ex. G (Letter from Homer Venters, MD, MS and Vincent Iacopino, MD, PHD, to the Honorable James N. Mattis, Secretary of Defense, September 8, 2017) (“Venters, Iacopino letter to SECDEF Mattis”).
- ⁶⁹ Reply to Respondent’s Memorandum in Opposition to Petitioner’s Emergency Motion for Medical Care, Attachment 5, Decl. of Sondra S. Crosby, MD, dated Sept. 3, 2013, at ¶ 10, *Alsawam v. Obama*, Case No. 05-cv-1244 (CKK) (D.D.C. Sept. 3, 2013) (“Crosby El Sawah Decl.”).
- ⁷⁰ Xenakis Dhiab Eval., *supra* note 23, at 5.
- ⁷¹ Brigadier General (Ret) Stephen Xenakis, MD, and Vincent Iacopino, MD, PhD, *Suffering Ex-Guantánamo Detainees Deserve Medical Care and Support*, PHR Blog, Oct. 13, 2016, available at <https://phr.org/resources/suffering-ex-guantnamo-detainees-deserve-medical-care-and-support/>.
- ⁷² Carol Rosenberg, ‘Sodomized’ Guantánamo captive to undergo rectal surgery, *Miami Herald*, Oct. 11, 2016, available at <https://www.miamiherald.com/news/nation-world/world/americas/guantanamo/article107451907.html>.
- ⁷³ *Id.*
- ⁷⁴ It seems that JTF-GTMO brings in outside specialists on a rotational basis, but they are military doctors (where trust is an issue), they may or may not have expertise in an area of medicine for which a detainee requires diagnosis or treatment, and they may not be on a rotational schedule that corresponds to timely medical care.
- ⁷⁵ Memorandum for CDR Patrick Flor, JAGC, USN, OCDC from Michael I. Quin, Legal Advisor to the Convening Authority for Military Commissions, dated February 11, 2014.

- ⁷⁶ For example, Mr. Al Hajj filed a motion for an independent medical evaluation on September 6, 2017. As of June 2019, the Court has not yet ruled on the motion. See Petitioner’s Emergency Motion for an Independent Medical Evaluation and Medical Records, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. Sept. 6, 2017).
- ⁷⁷ For additional details, see case study of Nashwan al-Tamir, *infra*.
- ⁷⁸ *Id.*
- ⁷⁹ Crosby Al-Nashiri Decl., *supra* note 52, at ¶ 12.
- ⁸⁰ Venters, Iacopino letter to SECDEF Mattis, *supra* note 68.
- ⁸¹ Unless otherwise noted, the information in Mr. al-Tamir’s case study is based on unclassified communications between Mr. al-Tamir and his defense counsel and unclassified portions of Mr. al-Tamir’s medical records.
- ⁸² Venters, Iacopino letter to SECDEF Mattis, *supra* note 68.
- ⁸³ al-Tamir Amended Habeas, *supra* note 68, at Ex. A (Letter from James C. Cobey, MD, MPH, FACS to counsel for Mr. Al Hajj, September 5, 2017).
- ⁸⁴ *US v. Hadi al-Iraqi*, AE 131E at 80, available at [https://www.mc.mil/Portals/0/pdfs/allIraqi/Al%20Iraqi%20\(AE131E\).pdf](https://www.mc.mil/Portals/0/pdfs/allIraqi/Al%20Iraqi%20(AE131E).pdf).
- ⁸⁵ Carol Rosenberg, *Pentagon shipping jumbo cell to Guantánamo court for al-Qaida trial from hospital bed*, McClatchy, January 14, 2019, available at <https://www.mcclatchydc.com/news/nation-world/national/national-security/guantanamo/article224302400.html>.
- ⁸⁶ Ghannam Supp. Al Hajj Decl., *supra* note 28, at ¶3, ¶5.
- ⁸⁷ *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) at 1-2, (D.D.C. May 23, 2011) (Memorandum Opinion).
- ⁸⁸ *Id.* at 2; see also Human Rights Watch, *Double Jeopardy, CIA Renditions to Jordan*, April 7, 2008, available at <https://www.hrw.org/report/2008/04/07/double-jeopardy/cia-renditions-jordan>.
- ⁸⁹ Petitioner’s Emergency Motion for an Independent Medical Evaluation and Medical Records, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. Sept. 6, 2017).
- ⁹⁰ *Id.* at Ex. A, Declaration of Pardiss Kebriaei at ¶ 4.
- ⁹¹ Government’s Opposition to Petitioner’s Emergency Motion for an Independent Medical Evaluation and Medical Records at 2, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. Nov. 27, 2017).
- ⁹² Ghannam Al Hajj Decl., *supra* note 48, at ¶ 3.

⁹³ *Id.*

⁹⁴ *Id.* at ¶ 6.

⁹⁵ *Id.* at ¶ 8 (Citing to case of Nashwan al-Tamir).

⁹⁶ *Id.* at ¶ 11.

⁹⁷ Petitioner's Motion for a Status Conference, *Al Hajj v. Trump*, Case No. 09-cv-745 (RCL) (D.D.C. October 26, 2018).

⁹⁸ Crosby El Sawah Decl., *supra* note 69, at ¶ 2.

⁹⁹ Ben Fox, *Some at Guantanamo jail too sick to keep locked up*, Associated Press, October 10, 2013, available at https://www.omaha.com/news/some-at-guantanamo-jail-too-sick-to-keep-locked-up/article_2f6e4916-336a-56b4-9a24-e8e913e15012.html.

¹⁰⁰ Matt Apuzzo, Sheri Fink and James Risen, *How U.S. Torture Left a Legacy of Damaged Minds*, *New York Times*, Oct. 8, 2016, available at <https://www.nytimes.com/2016/10/09/world/cia-torture-guantanamo-bay.html>.

¹⁰¹ Crosby El Sawah Decl., *supra* note 69, at ¶ 15.

¹⁰² Gleason Decl., *supra* note 54.

¹⁰³ Reply to Respondent's Memorandum in Opposition to Petitioner's Emergency Motion for Medical Care at 2, *Alsawam v. Obama*, Case No. 05-cv-1244 (CKK) (D.D.C. Sept. 3, 2013) ("Petitioner's Reply – El Sawah").

¹⁰⁴ *Id.* at 10.

¹⁰⁵ It is not clear whether the government claimed that leg shackling had never been required, or if JTF had simply reversed a recently instituted policy when Mr. El Sawah's counsel raised concern with the JTF Commander the day before filing the emergency motion. According to Dr. Xenakis, to the extent that leg shackling was required Mr. El Sawah's "medical conditions and daily functioning prohibit him from ambulating and conforming to the requirement of shackling for transportation. These conditions are unrealistic and interfere with his receiving appropriate medical testing and care." Petitioner's Emergency Motion for Medical Care, Attachment 1, Decl. of Stephen Xenakis dated August 21, 2013 at ¶ 5, *Alsawam v. Obama*, Case No. 05-cv-1244 (CKK) (D.D.C. Aug. 21, 2013) ("Xenakis el Sawah Decl.").

¹⁰⁶ Dr. Crosby disagrees: "Given his large size, arm shackles likely would interfere with his ability to ambulate, limit his chest excursion, and exacerbate his symptoms. I would have to observe Mr. El Sawah in shackles to arrive at a definitive opinion on this issue." Crosby El Sawah Decl., *supra* note 69, at ¶ 13.

¹⁰⁷ Petitioner's Reply—El Sawah, *supra* note 103 at 7-8.

¹⁰⁸ Following Dr. Crosby's September 3, 2013 declaration, Mr. El Sawah was visited by a pulmonologist (9/18/13), an otolaryngologist (9/19/13), an internist (9/26/13), Behavioral Health (9/4/13), a cardiologist, and a nutritionist. He had an arterial blood gas performed on September 13, 2013, and pulmonary function tests performed September 16, 2013.

¹⁰⁹ Unless otherwise noted, the information below is sourced to the Crosby El Sawah Decl., *supra* note 69.

¹¹⁰ Xenakis El Sawah Decl., *supra* note 105, at ¶ 5.

¹¹¹ Crosby Al-Nashiri Decl, *supra* note 52, at ¶¶ 12, 18.

¹¹² Senate Select Committee on Intelligence, Committee Study of the CIA's Detention & Interrogation Program (2014), at 66-73; *In re Al-Nashiri*, 835 F.3d 110 (D.C. Cir. 2016) (Tatel, J., dissenting).

¹¹³ *In re Al-Nashiri*, 835 F.3d at 110.

¹¹⁴ Crosby Al-Nashiri Decl. *supra* note 52, at ¶ 12.

¹¹⁵ *In re Al-Nashiri*, 835 F.3d at 142.

¹¹⁶ *U.S. v. Abd Al Rahim Hussayn Muhammad Al Nashiri*, Unofficial/Unauthenticated Tr. at 4238.

¹¹⁷ *Id.* at 4237, 4226.

¹¹⁸ *Id.* at 3842.

¹¹⁹ *Id.* at 3745.

¹²⁰ *Id.* at 3842.

¹²¹ *Id.* at 3830, 3831.

¹²² *Id.* at 4229-31.

¹²³ *Id.* at 4244-45, 4214-15, 4259-62.

¹²⁴ *Id.* at 3745.

¹²⁵ *Id.* at 4214-15.

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