

Silent healers

On medical complicity in torture

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Abstract

Objective: To shed light on a large but neglected human rights issue that can be termed passive participation in torture. This is a response to the rising number of statements from torture victims who claim that during their incarceration, medical personnel cooperated with the interrogators by sharing medical documents, giving false statements, and providing other indirect assistance to the interrogator.

Method: Cases studies are used to demonstrate the existence of passive participation, as well as situations where the passivity has been addressed and improved.

Extracts of international instruments and actions undertaken by associations are used to help the reader address issues around the passive participation in torture.

Result: By reading this article medical professionals will be made aware that action can be undertaken with the help of existing international laws and policies.

Conclusion: In the conclusion of the article a range of bullet-points is made available for medical professionals who want to address the issue of passive participation.

Keywords: active and passive participation of health personnel in torture, medical professional, universal declaration, medical ethics, AMA, APA, Israel, U.S.A, South Africa, Chile, dual loyalty, international law, human rights

Introduction

When we commonly think about the involvement of doctors or other health care personnel in torture, cruel, inhuman or degrading treatment, or punishment, we usually think about the atrocities performed during the Second World War by health personnel in the name of medicine. It is for this reason that characters such as Joseph Mengele¹ are famous. As with other health personnel, he conducted medical experiments on Jews in Birkenau concentration camp in Auschwitz. Among other things Mengele introduced grass into detainees' bodies, with the intention of understanding how an infection worked. Even though this murderer escaped, his fellow colleagues were charged and condemned in the Nuremberg trial². Modern international law regarding health professionals is based on the human rights issues that were addressed during the Nuremberg trial. Justice and society agree today to condemn health personnel who are involved in atrocities. At times it is suggested to condemn them to an even larger sentencing, due to their medical responsibility, which will be demonstrated later on.

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It is easy to recognise that someone who purposefully injected a virus or performed a forced sex-change operation is guilty of cruel and inhuman treatment. It may be less easy to condemn, with the same conviction, someone whose only action was not to oppose the torture of her or his patient. Nevertheless, in many cases, medical professionals who participate passively in these actions possibly join the same category as the torturers. For example, a circumstance might arise in which a state-agent requests a doctor to make a diagnosis of a detainee. If the doctor identifies symptoms of torture and does not demand an immediate end to the procedure, the doctor is indirectly legitimising the action of torture (see for instance the Tokyo and Hamburg declarations).

A medical professional working in a state prison might lose a patient's medical history on purpose, knowing that the information inside could be used by international organisations like Amnesty International or the Red Cross. In the two examples above, the doctor is not seen as directly involved, but does comply with a third party, often a state agent, that does not have in mind the best interest of the patient. The main purpose of this paper is to bring to light this invisible complicity, namely *passive participation*, in contrast to *active participation*. The reasons behind this silent acceptance might be manifold, such as believing that the state has the right to torture people that represent potential security threats³, resignation due to an overwhelming problem or simply the fear of getting hurt.

According to Steven H. Miles, author of "Oath Betrayed,"⁴ somewhere between 20 and 50 percent of torture survivors report "... seeing physicians serving as active accomplices during the abuse". These numbers, Miles explains, do not contain any figures regarding physicians who falsify medical

records or detainees' death certificates, nor do the figures take into account torture techniques designed by medical professionals. Another reason for why there is little data on this issue is that there is more focus on human rights in general, and less on torture⁵ in particular. Reports of passive participation are therefore almost impossible to find.

Grounds for accepting torture

The case of doctors

A major factor for the medical professional to comply with passive participation in torture is probably dual loyalty. Physicians for Human Rights (PHR) and the University of Cape Town (UCT) in South Africa defines this situation as "a clinical role conflict between professional duties to a patient and perceived or real obligations to the interest of a third party, and focuses on instances where the human rights are in jeopardy".⁶ The effect can be that a doctor turns a blind eye to a criminal offence at work, such as torture, and by doing this becomes a passive part of the involuntary extraction of information from a patient. See the 2002 report from Physicians for Human Rights on the six types of dual loyalty:⁷

- A Using medical skills or expertise on behalf of the state or other third party to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment.
- B Subordinating independent judgement, whether in evaluative or treatment settings, to support conclusions favouring the state or other third party.
- C Limiting or denying medical treatment or information related to treatment of an individual in order to effectuate policy or practice of the state or other third party.
- D Disclosing confidential patient information to state authorities or other third

parties in circumstances that violate human rights.

- E Performing evaluations for state or private purposes in a manner that facilitates violations of human rights.
- F Remaining silent in the face of human rights abuses committed against individuals in the care of health professionals.

These are common situations that we can qualify as passive participation in torture, cruel, inhuman or degrading treatment, or punishment. Unlike other kinds of more active participation, these last cases are rarely revealed, nor punished. The passive participation of health care personnel in torture and other cruel treatment is far less recognized and punished compared to cases of active participation. This difference is embedded in the nature of torture, which forces the victim to remain in the shadow of society and requires him or her to remain silent about the abuse. The nature of passive participation itself also contributes to the difference between prosecution of its agents and those who participate more actively.

Since the doctors who participate passively are actually guilty of not reporting any data, it remains very difficult to document a passive act. It is also very difficult to find the guilty medical professional, since the victims may not even get to see them. A case example is Amin Shqirat, who was in detention on 28th December, 2004. He explained that “They brought me to a doctor who examined me and then returned me to the interrogation blindfolded and handcuffed.”⁸ As he was blindfolded, it would not be possible to prosecute anyone without written evidence.

The program director of the working-group between PHR and UCT (see the above section), Leonard Rubenstein, has identified four circumstances in which health

professionals can find themselves in a situation of dual loyalty, and accordingly where the human rights of the client can be violated.⁹ A situation of dual loyalty can, first of all, be explained by a *lower quality of care*. This might be due to a variety of reasons such as the culture at the institution, local pressure, or national laws demanding sub-treatment of certain ethnicities. Confronted with dual loyalty, doctors employed in a prison might *remain silent*. They sometimes do not report to authorities, or other institutions or organizations that might help to improve the human rights of the patient. The health personnel might also have to *impose medical procedures to serve state interests*. One example can be the use of chemicals in a torture related situation, as well as supervision and injection during an execution. Finally, there are cases of *compromising one’s medical judgment*, for example when a medical forensic expert overlooks compromising evidence of torture for the benefit of a third party, often the state.

Dual loyalty is not the only reason for health professionals to accept being implicated in torture. Amnesty International (AI), in their report called “Doctors and Torture”,¹⁰ lists five reasons for why medical professionals might be involved in torture: *Bureaucratic necessity* is equivalent to a situation of dual loyalty since this relates to medical professionals who find it difficult to go against the wishes of their employer. Persuasion might work with the use of ideology, for instance claiming the importance of the security of the state, and the significance of the health professional’s help. Health personnel can, for instance, be *pressured or threatened* not to tell anyone what is going on, they can lose their job, or receive threats to their family. *Workplace pressures* are similar to the last point, and are also a part of the dual loyalty problem. Pressure is put on the med-

ical personnel, by the use of expectations or threats, to stay loyal to the institution that they work for. *Lack of awareness of medical ethics* is a problem when medical personnel think that if they do not participate in the actual torturing, they are not in breach of medical ethics. This is of course incorrect.

AI, in "Prescription for Change Health professionals and the exposure of human rights violations",¹¹ also gives 11 more examples for why medical professionals may fail in reporting human right violations.

The case of medical organisations and institutions

Another major issue that needs attention is the institutional acceptance of passive participation. An example of an organisation that indirectly supports torture is the American Psychological Association (APA). On the surface APA seems to be following the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT). The statement on their Web-Pages declares that the "APA has made absolutely clear that it is always unethical for a psychologist to participate in torture or cruel, inhuman or degrading treatment in any setting for any purpose".¹² This declaration is written in its full length under the APA resolutions, and is an adoption of the UNCAT.

When the APA, in their reaffirmation 19th August 2007, defines torture or cruel, inhuman, or degrading treatment, or punishment, it is not in the lines of the UNCAT definition. The policy is instead founded on the (John) McCain Amendment¹³ that rests on the 5th, 8th and 14th amendments of the Constitution of the United States of America.¹⁴ The problem with using these amendments is that they are not clear about the exact definition of torture and cruel, inhuman, or degrading treatment, or punish-

ment. The amendments demand that the detainee has been charged for a criminal act, and they do not apply to non-U.S. citizens located outside the U.S.¹⁵ It is through the application of this policy that health professionals such as John Leso, a behavioural psychologist, can be a member of the APA and still design interrogative techniques to be used in the detention facilities at Guantanamo Bay.¹⁶ In the drafting of an APA ethical report in 2006, no less than six of the ten board members had "close ties"¹⁷ with the army of the United States. Four of the six had also served in American detention centres in either Guantanamo, Abu Grahیب or in Afghanistan. The relationship between psychologists and the army of the United States has a long history¹⁸ and is, for this reason, an example of dual loyalty on an organisational level. It is not surprising that the APA has not taken stronger measures to ban torture and other cruel, inhuman, degrading treatment, and punishment, since this would have grave repercussions on the financial income of this institution.^a

Physicians for Human Rights-Israel (PHRI) state in their paper "Physicians and Torture-The Case of Israel"¹⁹ that the Israeli Medical Association (IMA) was far too lenient in its definition of torture and other cruel, inhuman, degrading treatment, and punishment. Much like the APA, the IMA had financial interests in maintaining a bond with the Israeli Security Agency (ISA, formerly known as GSS, General Security Service). Although the IMA board has on several occasions promised PHRI to improve the definition, it remains to be seen. PHRI

a. More about the role of the APA, the response from this organisation and its commitment can be found in the Appendix of this issue of TORTURE.

believe that all physicians in Israel should take a stand against any form of torture and other cruel, inhuman, degrading treatment and punishment, since physicians in Israel, like in the U.S., “do not face any threat to their lives.”

Expected higher moral standard

The latter paragraph raises another critical issue: What is expected by the medical professional? If the medical professional is threatened with direct violence, should she or he yield? The case of Gerard Ntakirutimana²⁰ is an example of a doctor who was eventually imprisoned for 25 years as a result of his actions during the Rwandan genocide. The importance of this case here is the emphasis that the International Criminal Tribunal of Rwanda (ICTR-96-10-1) put on his position as a medical professional when they gave him his sentence. Not long after the conflict ended, Doctor Gerard Ntakirutimana was found guilty of genocide and crimes against humanity by the tribunal. The Court emphasized that: “As a doctor, he was one of the few individuals in his area of origin to have achieved a higher education and one of the rare schooled in Western universities. It is particularly egregious that, as a medical doctor, he took lives instead of saving them. He was accordingly found to have abused the trust placed in him in committing the crimes of which he was found guilty.”²¹ The case of Gerard Ntakirutimana

is extreme in its contents, and also a rare juridical example of how the medical profession is expected to uphold an even higher standard than that of non-medical professionals.

Instruments and Institutions that help to counter torture

The contributions of the WMA and other associations

Despite the regrettable position of a few medical organizations, many others have created guidelines that concern how medical professionals are somehow implicated in torture. These guidelines and policies address what is expected of medical professionals, as well as what the medical professionals can expect of the international community. In this context, the Tokyo Declaration from 1975,^b adopted by the World Medical Association (WMA), aims specifically at medical personnel and condemns all actions that could passively or actively harm a patient. This declaration is today internationally recognised and available for any medical professional.

In addition, in its Hamburg Declaration of 1997,^c the WMA details the rights and duties that can be expected from a medical doctor in a torture-related situation. It is also reaffirmed that there is never any excuse for violating human rights.

A few years later, in a 2002 resolution,^d the WMA asked medical professionals to

b. Adopted by the WMA during their 29th Assembly in Tokyo, the declaration was revised in 2005 and in 2006. www.cirp.org/library/ethics/tokyo.

c. World Medical Association declaration concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment. Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997.

d. World Medical Association resolution on the responsibility of physicians in the documentation and denunciation of acts of torture or cruel or inhuman or degrading treatment. Initiated: September 2002. Adopted by the WMA General Assembly, Helsinki 2003 and amended by the WMA General Assembly, Copenhagen, Denmark, October 2007.

report cases of torture, as well as to report individual healthcare personnel involved or affiliated with torture, to the proper authorities. It calls for medical professionals to avoid any affiliation with torture.

Some other protocols are results of a wide collaboration of many actors. The Istanbul Protocol^e was initiated by the Human Rights Foundation of Turkey (HRFT) and the Physicians for Human Rights U.S.A. (PHR U.S.A.) and involved more than 40 different organisations. It became an official U.N. document in 1999.

Regarding the position adopted by other medical professions, the International Council of Nurses (ICN)^f states that the primary concern for a nurse is the patient who needs nursing.^g The ICN endorses the 1948 Universal Declaration of Human Rights and the 1949 Geneva Convention.

International law

After the atrocities during the Second World War, torture has, for the first time, become part of an international declaration. The Universal Declaration of Human Rights (UDHR) states, in its article 5, that “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”.²² After the Declaration of 1948, there was a codification process of torture, reflecting a global concern for condemning this practice.

e. Manual to assist the researcher while gathering information regarding accusations of torture. It is a tool for collecting evidence and shows how to report any findings.

f. Federation with 124 local nurses' associations worldwide.

g. Nurses' Role in the Care of Detainees and Prisoners, Position Statement adopted in 1998 and revised in 2006.

The first regional treaty to denounce torture was the European Convention of 1950²³ which states that “No one shall be subjected to torture or to inhuman or degrading treatment or punishment.” The European Convention is also the only one to allow an individual to take a state party to court.

Soon after, in 1948, the United Nations found the need to fit the human rights, mentioned in the UDHR, into an enforceable international instrument. Facing the difficulty of creating a single treaty that would include the 30 articles of the UDHR, the General Assembly ended up adopting two distinct covenants in 1966: the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Both of these came into force in 1976. The two covenants were made separately, so as to bypass the problem of differing perceptions expressed by the states involved. This way, states with different concepts of, for instance, economic rights could still agree on political issues, and sign a joint covenant. ICCPR devotes its article 7 to the prohibition of torture, saying that: “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.”²⁴

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) came into force in 1987. Ratified by 144 states, the UNCAT is the first international treaty entirely devoted to the prohibition of torture, which expresses the increasing international concern for this issue. It states that the State Party shall take effective measures to prevent torture and that no exceptional circumstances may be invoked as a justification of torture.²⁵ In order to look at all questions

regarding this topic, the UN also appointed a Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. This Special Rapporteur has a mandate for all countries.

Torture is banned at all time, and there are no exceptions. In the area of humanitarian law, the Third Geneva Convention, states that “No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind”.²⁶

Several other specialized international conventions mention the prohibition of torture, like the Convention on the Rights of the Child, in its article 37.²⁷ The High Commissioner for Human Rights has also recalled that the passive participation of medical professionals in torture was a “gross contravention of medical ethics”. In one document it states six principles that physicians should follow at all time.²⁸

It is therefore illegal to be implicated with torture and other cruel, inhuman or degrading treatment or punishment under any circumstance and medical professionals should take action to comply with international law. On this point, the Council of Europe has made a list of recommendations which addresses the responsibilities of medical professionals to act in accordance with international law.²⁹

Obstacles to stopping passive participation in torture

There are deeper issues that need to be addressed in the process of eliminating passive participation in torture. These are created by a flawed system and can be corrected when addressed. The purpose of this section is therefore to point out six issues that need to

be addressed in the interest of stopping passive participation in torture.

The first issue is the negligence by society as a whole. There is an automatic belief that the torture victim “had it coming” and that the governing state is flawless. Medical professionals are in no way excluded from thinking like this, and may use it as an excuse not to act. More information regarding reasons for getting tortured should be easily available to read. Some examples of reasons to perform torture may be to suppress political activists, forcing false testimonies on scapegoats, and using the threat of torture to suppress an entire population.

The second issue is the need for more mandatory classes on medical ethics. All faculties dealing with any form of medical professionals should have mandatory classes on medical ethics. In doing this it will be easy for any medical association to exclude a member, since the member will know that she or he has breached a human right. This would create an even larger space for ethical reinforcement.

The third issue is the pressure stemming from issues of dual loyalty. Dual loyalty puts an immense expectation on the individual medical professional to act in accordance with a third party. Any change of internal procedures of hospitals, jails and other work stations for medical professionals could help prevent possible situations of dual loyalty.

The fourth issue is the lack of transparency. All organisations and institutions should have open records at all times. If there is a request to see if a medical professional worked at a specific time, this information should be available. In this manner it would be possible to verify or disprove an accusation from a torture victim. The public should have access to all information related to financial affiliations, work locations and staff records, as long as this does not affect

the confidentiality of a patient. To achieve this in the workplace, it is important that medical professionals ask for the implementation of such a system.

The fifth issue is the role of the state and the police. Torture is often performed under state regulation. That means, like in the South African case, that health care professionals are expected to obey a third party, and not the best interests of their patient. This has a grave effect on those that have had their human rights violated. Documents that can prove an act of torture are very hard to find, since the local government does not want to expose itself as torturous. The medical professionals that are implicated in torture are therefore often protected by the state and the police. However, if the medical professional should want to protect the torture victim, then she or he would possibly have to rely on international policies and laws.

The sixth issue is the lack of enforcement in international law. There has not been much action taken on the issue of passive participation, and the only way to change this is a heightened interest from the international court to address the problem, which can be addressed by signing petitions supporting this view.

A case of successful fight for human rights

The Medical College in Chile, and its struggle for human rights

The Chilean Medical College can serve as an example of a medical institution that fights, both in the past and present, for human rights. Unlike the APA and IMA, this struggle does not depend on the severe threats that have been given to the people involved in the conflict. The Chilean Interior Minister writes that from 11th September 1973 until 10th March 1990, no less than

28,459 people were victims of political imprisonment or torture in Chile. Of these 1,244 were younger than 18, and 176 were younger than 13.³⁰ The period from 1973 until 1990 was marked by the dictatorship of Pinochet, the commander of the Chilean army, and leader of a rebellion that took control of the country.³¹ The number of victims during this period is likely to be much higher than reported, since the police that helped gather this information after the end of the rule of Pinochet were the same police-officers that helped him during his rule.

The Medical College of Chile (MCC) is, like the Turkish Medical Association (TMA), willing to use their influence to change the behaviour of their members. The MCC and TMA stress human rights and enforcement of medical ethics in societies where opposing the authorities could hold grave outcomes on the lives of the protesters. The MCC has already expelled Dr Vittorio Orvieto Tiplitzky in September 2005, Dr Hernán Horacio Taricco Lavín in 1989, Dr Osvaldo Leyton Bahamondes in 1991, and currently Dr Pedro Valdivia Soto is under investigation. The four doctors have been expelled, or are under investigation, due to their complicity in the kidnapping and murder of Manuel Leyton. The first of the four doctors involved in this particular case was expelled from MCC as early as 1989, and though it has taken some time, the effects of the MCC policy can now be seen to have an influence on the Chilean legal system. On 24th July 2007, Chilean Judge Alejandro Madrid started the process of prosecuting 13 health professionals, doctors and nurses for their involvement in the murder of Manuel Leyton.³² All of the above-mentioned doctors form a part of the implicated 13, as well as the chief nurse of the Londres clinic Eliana Carlota Bolumburu Taboada, who has now been expelled from the Chilean College for Nurses.³³

The South African grassroots movement of medical practitioners

In Chile and Turkey it was the medical associations that drove the legal system into taking action. In South Africa it was, to the contrary, a grassroots movement of health professionals, who, with the help of the court, in the end forced the national medical association to take action against two of their members. The two health professionals were Doctors Benjamin Tucker and Ivor Lang, both accomplices to the death of Stephen (Steve) Bantu Biko. Steve Biko was a human rights activist working against the South African apartheid, and he died while being in detention in 1977. Dr. Tucker and Dr. Lang both stated that the physical condition of Steve Biko was good enough to allow a transport from Port Elizabeth to Pretoria, some 800 miles away.³⁴ The doctors were accused of not having performed a proper medical examination, as well as falsifying medical documents. On the 17th of October 1985, the South African Medical and Dental Council stripped Dr. Tucker of his medical license for three months, and gave Dr. Lang a reprimand. Dr. Tucker was treated harsher, as he was the district surgeon, and had been Dr. Lang's supervisor.

The road to the ruling in 1985 was long, and had been pushed forward by both individual health professionals, as well as the South African Supreme Court (SASC). South Africa's Medical and Dental Council (SAMDC) had first ruled, in 1980, that the two doctors had done nothing wrong, when they had been excused on all points. This led to a protest to the Medical Association of South Africa (MASA), which retained the verdict by the SAMDC in 1980. The ruling first changed after protests from individual doctors pleading with SASC, which subsequently concurred with the protests, and told the SAMDC to make a new inquiry.³⁵ In this

latter judgment, the ruling changed⁴³⁶ One of the most infamous cases involving inappropriate and negligent care of a detainee by district surgeons was the death of Stephen Bantu Biko.³⁷ In the case of Biko, TRC found six points to demonstrate the failures made by the doctors Tucker and Lang:

"1) maintain patient-doctor confidentiality norms; 2) treat their patient with dignity and respect; 3) examine the patient thoroughly; 4) record and report injuries accurately; 5) diagnose illnesses and prescribe appropriate medication; 6) register complaints (particularly pertaining to assault and torture)."³⁸

Actions that can help prevent the passive participation in torture

What doctors can do

- Be prepared to work in a situation that is highly influenced by a culture of dual loyalty, and always remember the law requires duty to their clients and not to a third party.
- Promote and reinforce human rights by warning international authorities or human rights organisations about any irregularities.
- Demand that all treatment is done without a third party in the room (see the Istanbul protocol, for proper procedure³⁹).
- Follow at all times the ethical principles designed for health care professionals in both ancient guidelines and modern international law.

What the medical institutions and organizations can do

- Promote transparency in all records.
- Reinforce human rights by expelling and prosecuting members that are proven to be in breach of human rights.
- Stay financially independent from any governmental institution.

- The faculties for health care professionals should provide a class of Human Rights, in order for the future health staff to be more aware of their duties and obligations regarding International Human Rights.
- Work on a clear definition of torture. Not to mistake torture for other cruel, inhuman or degrading treatment or punishment.
- Not use the word torture excessively, since this weakens the meaning.

What can be done in international law

- Search and punish examples of passive participation, to reinforce the existing laws.
- Demand more from institutions and organisations, and create a checklist of minimum responsibility.
- Implement preventive systems to search in institutions and organisations for signs of dual loyalty.
- More norms regarding health personnel's obligation to their patients.
- Dual loyalty should not be allowed as an excuse for the participation in torture. Human Rights should be, by nature and in essence, superior to any governmental policy.
- The court should be less lenient with the accused that does not have any hard evidence against them. However, this trend is turning. International courts are starting to take the stand that should there be no evidence to the contrary, it is the victim that should be believed.

What you can do as a private person

- Help society to understand the reality of torture by bringing it up in debates.
- Help victims of torture to be reinserted into society by supporting and helping them to give their testimony.

References

1. Mengele J. Jewish Virtual Library. www.jewishvirtuallibrary.org/jsource/Holocaust/Mengele.html.
2. The Nuremberg Trials: the doctors trial. www.law.umkc.edu/faculty/projects/ftrials/nuremberg/NurembergDoctorTrial.html.
3. Institutional hearing: the health sector. In: Truth and Reconciliation Commission of South Africa Report, vol. 4, chap. 5.
4. Miles S. Oath betrayed: torture, medical complicity, and the war on terror. Random House, 2006: 24.
5. Appeal for increase of European contribution to fund for victims of torture. IRCT News & Media. www.irct.org/Default.aspx?ID=3558&M=News&NewsID=200.
6. Health professionals and torture: resources & background reports. AAAS Science and Human Rights Program. http://216.239.59.104/search?q=cache:3W9NwumJoesJ:shr.aaas.org/emerging_issues/healthprofessionalsandtorture.htm+Health+Professionals+and+Torture:+Resources+%26+Background+Reports&hl=no&ct=clnk&cd=1&client=firefox-a.
7. Dual loyalty & human rights in health professional practice. Proposed guidelines & institutional mechanisms. Physicians For Human Rights, 2002.
8. Ticking bombs. Testimonies of torture victims in Israel. PCATI, 2007.
9. Solomon MZ, ed. Healthcare professionals and dual loyalty: technical proficiency is not enough. *Med Gen Med* 2005;7(3):14.
10. Why doctors get involved. In: Doctors and torture. Amnesty International, 2002:chap. 2. <http://archive.amnesty.org/library/Index/ENGACT750012002?open&of=ENG-390#top> (March 1, 2002).
11. Prescription for change: health professionals and the exposure of human rights violations. Section 3. Amnesty International, 1996.
12. American Psychological Association. Frequently asked questions regarding APA's policies and positions on the use of torture or cruel, inhuman or degrading treatment during interrogations. www.apa.org/releases/faqinterrogation.html.
13. Babington C, Murray S. Senate supports interrogation limits. *The Washington Post*, October 6, 2005. www.washingtonpost.com/wp-dyn/content/article/2005/10/05/AR2005100502062.html
14. Reaffirmation of the American Psychological Association position against torture and other cruel, inhuman or degrading treatment or punishment and its application to individuals defined in the

- United States Code as “enemy combatants”. Resolution adopted by APA on August 19, 2007.
15. Interrogation of detainees: overview of the McCain Amendment. Congressional Research Service Report for Congress, 2006. www.fas.org/sgp/crs/intel/RS22312.pdf.
 16. Open Letter to Sharon Brehm. American Psychological Association, 2007. www.ipetitions.com/petition/BrehmLetter/signatures.html
 17. Benjamin M. Salon 8/4/2006. Psychologists group still rocked by torture debate. www.salon.com/news/feature/2006/08/04/apa/index_np.html
 18. Levine A. Collective unconscionable. *The Washington Monthly*, January/February 2007. www.washingtonmonthly.com/features/2007/0701.levine.html
 19. Ziv H. Physicians And Torture - The Case Of Israel. Physicians for Human Rights – Israel, 2007. www.stoptorture.org.il/eng/images/uploaded/publications/35.pdf
 20. International Criminal Tribunal for Rwanda. NTAKIRUTIMANA, Gérard, 1: ICTR-96-10; 2: ICTR-96-17. <http://69.94.11.53/default.htm>.
 21. Truth and Reconciliation Commission. Chap. 5. Sentencing, paragraph 910. <http://69.94.11.53/ENGLISH/cases/NtakirutimanaE/judgement/ch5.htm>.
 22. UN Universal Declaration for Human Rights. 1948.
 23. Convention for the Protection of Human Rights and Fundamental Freedoms. Article 3. 1950.
 24. UN Covenant on Civil and Political Rights. 1966.
 25. United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Article 2. 1984
 26. Third Geneva Convention relative to the Treatment of Prisoners of War. Article 17. 1949.
 27. Convention on the Rights of the Child. 1989.
 28. The United Nations Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. 2005.
 29. Council of Europe. Recommendation No R (98) 7 concerning the ethical and organisational aspects of health care in prison.
 30. Comisión Nacional De Prisión Política Y Tortura. Ministerio del Interior del Chile. www.comisiontortura.cl/index.html.
 31. Key dates in General Augusto Pinochet’s career. *The New York Times*, December 10, 2006.
 32. Caso Berrios: corte negó libertad a oficiales uruguayos. *Prisioneros de guerra fach*. Cronología N° 96 (28/06/06). www.prisionerosdeguerrafach.cl/masnoticias.asp?id=217.
 33. Declaración Pública: Colegio Rechaza Actos Enfermera Involucrada En Caso Leyton. Colegio de Enfermeras, 2007. www.colegiodeenfermeras.cl/info.asp?Ob=1&Id=1153.
 34. Rule Sheila: Pretoria doctor loses his license. *The New York Times*, October 17, 1985.
 35. Human rights and health; the legacy of apartheid. Science and Human Rights Program. <http://shr.aaas.org/loa/contents.htm>.
 36. Institutional hearing: the health sector. Final Report. Vol 4. Chap 5. Par 139. Truth and Reconciliation Commission, 1998.
 37. Institutional hearing: the health sector. Final Report. Vol 4. Chap 5. Par 12. Truth and Reconciliation Commission, 1998.
 38. Institutional hearing: the health sector. Final Report. Vol 4. Chap 5. Par 144. Truth and Reconciliation Commission, 1998.
 39. Istanbul Protocol or Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. 1999.