

Doctors' involvement in torture

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Abstract

Doctors from both non-democratic and democratic countries are involved in torture. The majority of doctors involved in torture are doctors at risk. Doctors at risk might compromise their ethical duty towards patients for the following possible reasons: individual factors (such as career, economic or ideological reasons), threats, orders from a higher ranking officer, political initiatives, working in atrocity-producing situations or dual loyalty. In dual loyalty conflicts, factors that might compromise doctors' ethical obligations towards detainees/patients are: ideological totalitarianism, moral disengagement, victim blame, patriotism, individual factors or threats. Another important reason why doctors are involved in torture is that not all doctors are trained in addressing human rights issues of detainees.

Torture survivors report that they have experienced doctors' involvement in torture and doctors themselves report that they have been involved in torture. Testimonies from both torture survivors and doctors demonstrate that the most common way doctors are involved is in the diagnosis/medical examination of torture survivors/prisoners. And it is common before, during and after torture. Both torture survivors and doctors state that doctors are involved during torture by treatment and direct participation. Doctors also falsify journals, certificates and reports.

When doctors are involved in torture it has devastating consequences for both torture survivors and doctors. The consequences for the survivors can be mistrust of doctors, avoidance of seeking doctors' help and nightmares involving doctors. Mistrust and avoidance of doctors could be especially fatal to the survivor, as it could mean a survivor who is ill may not seek medical attention. When the unambiguous role of the doctor as the protector and helper of people is questioned, it affects the medical profession all over the world.

Keywords: Torture, doctors at risk, dual loyalty, prison, police, terror laws, conventions

Introduction

Torture is often associated with dictatorial military regimes, police states and other non-democratic governments. This is true, however, it can also be associated with western and democratic countries. This has especially been brought to the attention of the public in the war against terror with numerous cases of coalition soldiers involved in torture.¹⁻⁶ This problem becomes bigger and more complicated by the policy of the political leadership in the U.S.A., who argue that the Geneva Convention is not in force in the war against terror due to the captured persons being considered terrorists who are entitled to prisoner of war status and therefore not subject to the Geneva Convention.⁷ Yet the U.S.A and other allied countries have signed the U.N.'s "Convention Against

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Torture”,⁸ which is in force both in war and in peace.⁹

Objectives

The purpose of this study is to focus on doctors’ involvement in torture. The objectives are to present, analyse and discuss the involvement of doctors from both democratic and non-democratic countries. Drawing from the referred literature, the study will investigate why, how and when doctors participate in torture and the amount of doctors involved. It will also investigate how many torture survivors have experienced doctors’ involvement.

Methods

The study is a literature study. Data was collected from the RCT Documentation Centre and the Internet in the period 28 February 2006-9 May 2007. Search words used were:

- Doctors; torture
- Dual; loyalty
- Doctors; participation
- Torture; doctors; participation; number

Furthermore articles were found by looking through the references of articles on these subjects.

Material

This study is based on: 1) studies of interviews with torture survivors,^{10,11} 2) studies of interviews with doctors,⁶ 3) articles and studies concerning doctors’ participation in torture.

Why doctors are involved in torture

For the following the two terms ‘doctors at risk’ and ‘dual loyalty’ are introduced.

Doctors at risk

“Doctors at risk” or “high risk doctors” are

terms used for doctors that have a higher risk of being involved in torture due to their work. These doctors include military, police and prison doctors and forensic medical specialists.¹⁰⁻¹⁵

Vesti¹⁴ has shown that out of 65 doctors (identified by the survivors) who were involved in torture, 48 (74%) were allegedly “doctors at risk”.

Earlier studies^{11,16} have focused on doctors living in non-western non-democratic countries where being a prison doctor or a military doctor would often mean indirect or direct involvement in torture. Therefore it is interesting to focus on *why* doctors became doctors in these areas. One study describes how the Iranian state offered medical training to family members of victims of the Shah’s regime and the war against Iraq and after taking part in this state funded education it would be difficult for these people to refuse to become a prison doctor.¹¹ Some doctors might have been more or less forced into working in these areas by threats of violence, torture or execution of their families or themselves, or the threat of having their authorisation taken away.^{11,16} Other doctors might have applied for jobs in these areas due to economic, career or ideological reasons.¹¹

Two new developments as a result of the war against terror illustrate why it may be “risky” to be a military, police or prison doctor or a forensic scientist in a “western” democratic country.

- In 2002 the command of Guantanamo “approved the creation of a ‘Behavioural Science Consultation Team’ (BSCT, pronounced ‘Biscuit’) in order to develop new strategies and assess intelligence production.”¹⁷ It is “composed of physicians, psychologists, and others not involved in providing clinical care, whose functions

include ,consulting on interrogation plan and approach, providing feedback on interrogation technique, assessing fitness for interrogation, and reviewing interrogation plans.”¹⁸

- In 2005 the U.S. Department of Defence (DoD) released new ethical guidelines: “Medical program principles and procedures for the protection and treatment of detainees in the custody of the armed forces of the United States”.¹⁹ The essence of the problem with these guidelines is illustrated by Rubenstein et al: “The DoD guidelines make no reference to torture and they may undermine a physician’s duty to provide humane treatment by (1) making a distinction between clinical and nonclinical activities, (2) linking ethical conduct to U.S. interpretations of ,applicable law’ and disregarding the possible risk of infliction of harm and the violation of international standards, and (3) eliminating even a partial duty to protect medical confidentiality.”¹⁸

Lifton²⁰ provides another view on why there is a risk being a military or prison doctor. He points out how “atrocious-producing situations” can be created. These are situations “so structured, psychologically and militarily, that ordinary people can readily engage in atrocities.”²⁰ With reference to Abu Ghraib, he explains how “doctors and other medical personnel were part of the command structure that permitted, encouraged, and sometimes orchestrated torture to a degree that it became the norm – with which they were expected to comply – in the immediate prison environment”.²⁰

Vesti and Lavi¹³ provide a similar conclusion: “Individual factors may have been of importance for motivation, but far more important seems to have been the organisation of the system.”

Discussion

Most doctors involved in torture are in the category ‘doctors at risk’. This clearly indicates the importance of focusing on these groups when discussing doctors’ involvement in torture.

The above distinguishes between doctors from countries with non-democratic regimes and doctors from democratic countries. Yet it can be concluded from the literature that there is little difference between the two. Both types of countries seem to find argumentation for and create situations that breed doctors’ involvement in torture.

Even when doctors are forced (by threats to their own or their families’ life and health) to participate in torture, it leaves them in an extremely difficult situation. Career, economic or ideological reasons are never acceptable for participation in torture. Doctors and medical associations have the responsibility to speak up against, and to refuse to follow guidelines set by governments that encourage doctors to participate in torture. “Doctors at risk” need to be familiar with the risk of “atrocious-producing situations” through their work and be careful not to adopt ideologies that could affect their ethical judgement.

By working with government forces and thereby being colleagues with soldiers, police officers and prison guards, or taking orders from the director of a prison or higher ranking officers, it is understandable why it is a risk working in these professions. In such situations it can be difficult accusing colleagues and friends of abuse of a detainee/prisoner. In many of these jobs you do not question orders from a person higher up in the hierarchy. Finally, and what may be the strongest reason why these professions are at a higher risk, is the often conflicting points of interest between the prisoner/enemy/patient and the employer/state and thereby the conflict of “dual loyalty”.

Dual loyalty

Physicians for Human Rights (PHR) has defined dual loyalty as: "Clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, insurer or the state."²¹

Various cases of doctors in dual loyalty conflicts have been described, such as doctors in Iraq under the Baathist regime,¹⁶ police doctors in Germany,²² U.S. military medical personnel in Iraq, Afghanistan and Guantanamo Bay,^{1,23-25} prison doctors in Denmark²⁶ and Canadian military physicians in Afghanistan.³

PHR has published a detailed report concerning dual loyalty and human rights containing examples and guidelines for health professionals.²¹

The ethical dilemma of dual loyalty in the war on terror is discussed by Singh:²⁴ "If the detainee is being subjected to poor detention conditions or 'robust interrogation' by the detaining power, state physicians could experience a conflict of interest between: a) their duty to care for and protect a ... detainee ... against abusive treatment ...; and b) their patriotic duty to protect and serve the interests of their country (which might arguably require the physician to remain silent about such treatment)."

He also describes how "social circumstances and particular factors" might influence some physicians to lose moral perspective and to facilitate abuse of detainees. These "circumstances and factors" are "ideological totalitarianism", "moral disengagement" and "victim-blame". "Ideological totalitarianism" can result from "the negative labeling or devaluing of a group by influential forces". "Moral disengagement" occurs when subordinates of a labeling group regard the interest of the labelled group as less relevant because of the political culture

under which they live." "Victim-blame" is a tendency to hold victims responsible for their own fate."²⁴

Furthermore, he describes how in South Africa, under apartheid, these factors facilitated abuse of detainees, and he asks physicians in the war on terror to be on guard to not "adopt this mentality" as it may compromise "their ethical obligations towards war on terror detainees". He recommends that in dual loyalty conflicts "the physician's core duty to care for the detainee patient must still prevail."²⁴

Discussion

By calling it "dual", it is acknowledged, that there are two parties that ask for loyalty. The problem is that a patient might be treated by a doctor who is not objective. A doctor's loyalty to patients is defined in the doctor's oath. A doctor's loyalty to the second party (military or state) is defined by the second party. To which party loyalty belongs is the ethical dilemma.

In the dual loyalty conflict in the war on terror described by Singh²⁴ above, he outlines some factors that might compromise military physicians' ethical obligations towards detainees/patients. These factors could be reasons for prison doctors compromising their ethical duties in spite of the fact they should not. Other reasons may be patriotism or threats.

The ethical dilemma for the patient is that they see the doctor as something other than only as their healer and protector and this undermines the role of doctors in general. If a patient can not completely trust a doctor to work only in their interest, it will affect the doctor/patient relationship. The patient may not be honest with their doctor and therefore not receive the correct treatment.

The U.N.,²⁷ World Medical Association

(WMA)²⁸ and PHR²¹ have created ethical guidelines for health personnel/physicians which state that in any situation in contact with patients, the patient's interests must always come first. If this is not followed, the risk of an unethical act by a doctor increases.

How and when doctors participate in torture

Interviews with torture survivors – literature

An examination by Rasmussen¹⁰ based on medical records with the aim to “describe the type and frequency of medical involvement in torture”, showed that 41 of 200 (20%) torture victims had experienced medical involvement and attention at the time of detention, recorded as the following:

- 4% of the 200 had experienced the non-therapeutic administration of drugs.
- 5% received medical examinations during torture. This included blood pressure measuring and auscultation of the heart. On the basis of the findings it was estimated if the torture could continue or had to be stopped.
- 7% received mouth-to-mouth resuscitation due to unconsciousness.
- 15% were examined by a doctor resulting in hospitalisation.
- 15% were examined and received treatment.

In a study by Vesti¹⁴ 42 torture survivors were asked the following questions: “whether a medical examination was carried out before torture”, “whether medical doctors had been involved after the onset of specific physical torture”, “torture was resumed after medical evaluation or treatment”, “the number of doctors involved in each period of detention and torture” and “the alleged status of the doctors ...”

The study showed that 42 torture survi-

vors endured 83 episodes of torture. 29 of 42 survivors experienced doctors' involvement in the first two weeks. Doctors were involved in 70% of the episodes of torture. 24% of the 29 survivors had been medically evaluated prior to torture and 86% had experienced medical attention in between torture sessions and were again tortured as a consequence of this. 65 doctors were described of whom 48 (74%) were characterised as “doctors at risk”.

In an article by Smidt-Nielsen¹¹ based on semi-structured interviews with 80 torture survivors receiving treatment at the Rehabilitation and Research Centre for Torture Victims (RCT), 33 (41%) had contact with medical personnel in connection with torture, 3 of 80 (4%) were examined by a doctor before torture, 6 of 33 (18%) were examined by a doctor during torture, 5 of 33 (15%) were treated by a doctor during torture, 2 of 33 (6%) experienced direct doctor participation in torture and 31 of 33 (94%) were inspected or treated by a doctor after torture; 14 of the 80 (18%) had changed their attitude towards doctors as a consequence of their imprisonment and torture, such as mistrust of doctors, avoidance seeking doctors' help and nightmares involving doctors.

Interviews with doctors

In 2004 the article “Physician Participation in Human Rights Abuse in Southern Iraq” by Chen Reis et al¹⁶ was published. It was based on a self-administered survey of 98 physicians and semi-structured interviews with more than 60 physicians. One of the objectives was “to characterise the nature of physician participation in human rights abuses ...”. The survey included questions on “... experience and knowledge of physician participation in human rights abuses since 1988 ...”.

Results (based on the 98 self-administered surveys):

- 71% found torture or ill treatment an “extreme” problem in Iraq since 1988.
- One half stated that physicians had performed non-therapeutic amputation of ears as a form of punishment and falsified medical-legal reports of alleged torture. One third stated that physicians had falsified death certificates.
- 8% stated that physicians had participated in torture.
- Physicians who had participated in human rights abuses was reported as followed:
 - 7% (6 of 90) had falsified death certificates.
 - 5% (5 of 91) had performed “non-therapeutic amputation of ears as a form of punishment”.
 - 4% (4 of 94) had falsified “medical-legal reports of alleged torture”.
 - 4% (4 of 92) had administered “mercy bullets” to survivors of torture or ill treatment”.
 - 3% (3 of 93) had released “medical records to state officials without patient content”.
 - 2% (2 of 92) had participated in torture.
- 93% “thought that physicians who participated in human rights abuses should be punished or reprimanded” 7% stated that doctors participating “in abuses should not receive any sanctions.”

In April 2005 the report “Assessment of detainee medical operations for OEF, GTMO, and OIF”⁶ was written by the U.S. Army Medical Department (AMEDD) Office of the Surgeon General as a response to the concerns by the Army Surgeon General “regarding the appropriate treatment of de-

tainees, including during interrogation, and access to medical care” in Iraq, Afghanistan and Guantanamo and as a response to earlier investigations made by the army and to reports in the press that have “alleged wrongdoings by military medical personnel”.

The purpose of the report was to provide “medical assessment focused on aspects related to: 1) detainee medical policies and procedures, 2) medical records management, and 3) the incidence and reporting of alleged detainee abuse by medical personnel ...”

The report is based on a prospective interview and questionnaire study. 1,182 personnel from over 180 military units were questioned.

The following focuses on the results relevant to this study. Not all medical personnel were asked the same questions, accounting for the differing n-numbers of interviewees in the brackets. It is not possible from the report to differentiate between doctors and other medical personnel and therefore to specify which doctors have answered or how many doctors were included in the report. So when this study refers to the interviewees in the above report they are here referred to as “doctors”.

Results (Table 1)

- The interviewees were asked if the overall unit training prepared them “for addressing human rights issues of detainees?” The result was that between 43% and 100% of personnel in each of the past, present and future groups from OEF, OIF and GTMO answered: Yes. However, 31% (307 out of 988) overall answered: No (this figure is calculated from the data given in the report).
- The interviewees were asked, “were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?”

Table 1. Results from the five studies.

	Out of the entire population	Out of the subpopulation †	Classification (Explanation for Table 2)
<i>Ole Vedel Rasmussen, 1990</i> ¹⁰	n=200	n=41	
Non-therapeutic administration of drugs	4% (9 out of 200)*	22% (9 out of 41)	During, direct participation
Medical examinations during torture	5% (10 out of 200)*	24% (10 out of 41)	During, diagnosis
Medical resuscitation including mouth-to-mouth method due to loss of consciousness	7% (15 out of 200)*	37% (15 out of 41)	During, treatment
Examined by a doctor resulting in hospitalisation	15% (30 out of 200)*	73% (30 out of 41)	After, diagnosis
Examined and received treatment	15% (31 out of 200)*	76% (31 out of 41)	#
<i>Peter Vesti, 1990</i> ¹⁴	n=42	n=29	
Medically evaluated prior to torture	17% (7 out of 42)	24% (7 out of 29)*	Before, diagnosis
Medical attention in between torture sessions and tortured as a consequence of this	60% (25 out of 42)	86% (25 out of 29)*	During, diagnosis
<i>Knud Smidt-Nielsen, 1998</i> ¹¹	n=80	n=33	
Examined by a doctor before torture	4% (3 out of 80)*	9% (3 out of 33)	Before, diagnosis
Examined by a doctor during torture	8% (6 out of 80)	18% (6 out of 33)*	During, diagnosis
Treated by doctor during torture	6% (5 out of 80)	15% (5 out of 33)*	During, treatment
Experienced direct doctor participation in torture	3% (2 out of 80)	6% (2 out of 33)*	During, direct participation
Was inspected or treated by a doctor after torture	39% (31 out of 80)	94% (31 out of 33)*	After, diagnosis and after, treatment
Mistrust of doctors	10% (8 out of 80)	57% (8 out of 14)*	
Avoidance to seeking doctor's help	8% (6 out of 80)	43% (6 out of 14)*	
Nightmares involving doctors	15% (12 out of 80)	86% (12 out of 14)*	
<i>AMEDD, 2005</i> ⁶	n=880‡	n=variates	
Pre-screening	5.2% (46 out of 880)	42% (46 out of 104)	Before, diagnosis
Present during interrogation	9.2% (81 out of 880)	9.8% (81 out of 827)	During, diagnosis
Provide medical care to detainees during interrogations so that the interrogations could be continued	0.8% (7 out of 880)	1.4% (7 out of 483)	During, treatment
Participation under interrogation	0.6% (5 out of 880)	0.6% (5 out of 793)	During, direct participation
Post screening	1.5% (13 out of 880)	14% (13 out of 96)	After, diagnosis

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	Out of the entire population	Out of the subpopulation †	Classification (Explanation for Table 2)
<i>Chen Reis et al, 2004</i> ¹⁶	n=98	n=variates	
Falsified death certificates	6% (6 of 98)	7% (6 of 90)*	After, falsification of journals, certificates or reports
Performed "non-therapeutic amputation of ears" as a form of punishment	5% (5 of 98)	5% (5 of 91)*	During, direct participation
Falsified "medical-legal reports of alleged torture"	4% (4 of 98)	4% (4 of 94)*	After, falsification of journals, certificates or reports
Administered "mercy bullets" to survivors of torture or ill treatment"	4% (4 of 98)	4% (4 of 92)*	During, direct participation
Released "medical records to state officials without patient consent"	3% (3 of 98)	3% (3 of 93)*	#
Participated in torture	2% (2 of 98)	2% (2 of 92)*	During, direct participation

#: Cannot from text classify it as being before, during or after torture.

*: Results given from the original articles.

†: Subpopulation consists of: Torture survivors that have experienced doctors' involvement,^{10,11,14} doctors who answered the questions,¹⁶ "doctors" who were actually asked the question.⁶

‡: Past (n=803) and Present (n=77) population, the two groups that have had contact with detainees.

The results were:

- 4.6% (30 of 658) of past and present Afghan/Guantanamo/Iraqi interviewees directly observed actual or suspected detainee abuse.
- 7.2% (63 of 874) had a detainee directly report alleged abuse to them. These two results can be calculated from the data given in the report.
- The interviewees were asked, "did any medical personnel aware of detainee abuse, or who treated actual or suspected detainee abuse, properly document the abuse?" The conclusion from the answers was that "although the majority of medical personnel aware of actual or suspected abuse reported the abuse to proper authorities, they did not consistently nor uniformly document such abuse in the medical record."
- In Iraq 7 of 483 (1.4%) "of interviewees

were asked to provide medical care to detainees during interrogations so that the interrogations could be continued".

- At facilities in Afghanistan and Iraq pre, post, or pre/post screening were:
 - Pre-screening: On average 42% (46 of 109) (calculated from the data given in the report).
 - Post-screening: On average 14% (13 of 96) (calculated from the data given in the report).
 - Pre/post-screening: 12% (3 of 25).
- "Doctors" present during interrogation was 81 of 827 (9.8%).
- In Iraq 5 of 793 (0.6%) "doctors" were asked to participate in interrogation.

The report describes the Behavioural Science Consultation Team (BSCT). The purpose of this team was "to provide forensic psychological expertise and consultation

to assist the command in conducting safe, legal, ethical, and effective interrogation and detainee operations” and one of their duties was to provide “assessment for the psychological fitness of detainees to be interrogated”. The team consisted of physicians/psychiatrists and psychologists. Regarding medical information on detainees, it is stated that “Several BSCT personnel did have access to the detainee medical records”.

Discussion

Doctors involvement according to testimonies from torture survivors

The three articles based on testimonies from torture survivors have quite different results concerning torture survivors experiencing doctors’ involvement in torture (20-69%). Vesti¹⁴ uses the inclusion criterion that the survivor had to have “been detained more than two weeks” and had to bear “obvious signs of physical torture”. The latter could mean that the persons included in the study were more severely physically tortured and because of this the chance of contact with a doctor was higher. Therefore Vesti’s study¹⁴ is well designed to show how and when doctors are involved in torture. However the study does not provide a representative result of the number of torture survivors who have experienced doctors’ involvement.

Due to Rasmussen’s¹⁰ retrospective study design, the survivors were not directly asked if they had experienced the involvement of a doctor. Therefore under-reporting is likely to have occurred.

Due to the prospective study design, the population size and the lack of inclusion criteria, Smidt-Nielsen’s¹¹ result provides the best picture of the percentage of torture survivors (41%) that have experienced the involvement of doctors. The weakness is that 93% of interviewees are from the Middle East and therefore the results might not rep-

resent torture survivors outside the Middle East.

A general problem (which is also recognised by the three authors) is the identification of doctors. All three set up similar criteria for when they could include the alleged doctor to actually be a doctor. The toughest criterion is set by Smidt-Nielsen (he demands “visual identification of a person who was dressed and acted like a doctor”¹¹) and therefore some of the episodes that would have been included by the two other authors might have been excluded in Smidt-Nielsen’s study.

Doctors’ involvement according to testimonies from doctors

A problem with the statements from doctors is that it is not clear if the doctors involved in torture were involved only once or several times. However the results can be seen as proof that doctors, according to their own statements, are involved in interrogation/torture of detainees. The results also provide an illustration of when in the process of interrogation/torture they are involved (Table 2).

In the study by Reis et al¹⁶ there is a maximum of 7% of respondents that state self-participation. 93% have not themselves participated in abuse and therefore the majority of the general findings in the article could be based on second-hand knowledge. For this reason only the results of the 7% of doctors who state they participated in abuse will be used in the analysis of how and when doctors participate in the torture process. However, the general results demonstrate that doctors do participate in torture.

Concerning the AMEDD report,⁶ it should be clarified that when a detainee is interrogated, it does not necessarily mean that he/she is tortured. But the report states that an average of 4.3% (with a maximum of

Table 2. Result of the five studies^{6,11,12,15,17} put into the classification model.

		Ole Vedel Rasmussen, 1990 ¹⁰ n=41	Peter Vesti, 1990 ¹⁴ n=29	Knud Smidt-Nielsen, 1998 ¹¹ n=33	AMEDD, 2005 ⁶ n=880/ n=variates according to doctors asked the question, see Table 1	Chen Reis et al, 2004 ¹⁶ n=variates according to self reported answers, see Table 1
<i>Before</i>	Diagnosis		24%	9%	5.2%/42%	
	Treatment					
<i>During</i>	Diagnosis	24%	86%	18%	9.2%/9.8%	
	Treatment	37%		5%	0.8%/1.4%	
	Direct participation	22%		6%	0.6%/0.6%	5%
<i>After</i>	Indirect participation					
	Diagnosis	73%		94%	1.5%/14%	
	Treatment					
	Falsification of journals, certificates or reports					7%

5%) of the “doctors” (of the subpopulation) “directly observed actual or suspected detainee abuse”,⁶ and that an average of 7.2% (with a maximum of 32.7%) of the “doctors” (of the subpopulation) “had a detainee directly report alleged abuse to them”.⁶ From these results it can be concluded that abuse does occur during interrogation/detention and therefore the results can be compared to the results of the four other studies.^{11,12,15,17}

When the word “abuse” is used in the AMEDD report it is defined as “treatment of detainees that violated U.S. criminal law or international law that was inhumane or coercive without lawful justification.”⁶ Examples of abuse in the report are: cigarette burns, being chained and dragged behind a vehicle and sitting handcuffed in 120 degrees Fahrenheit (49 degrees celsius) for nine hours.⁶ Both the Convention Against Torture (CAT)⁹ and the Tokyo Declaration²⁸

would characterise these examples as torture.

The AMEDD report⁶ is assigned by the Army Surgeon General (head of AMEDD) to employees of AMEDD to investigate other employees of AMEDD. This might result in a conflict of interest.

The AMEDD report⁶ undermines the value of some of its results. Almost one third of past, present and future deployers answered “No” when asked if the overall unit training prepared the “doctors” “for addressing human rights issues of detainees?”.⁶ This is a violation against CAT, article 10.1⁹ and could be the answer as to why doctors are involved in torture. Doctors who have not learned how to address human rights issues of detainees are at a higher risk of being involved in torture than doctors who are familiar with the law.

The role of BSCT (Behavioural Science Consultation Team) must be discussed.

AMEDD and the doctors in BSCT defend the role of BSCT (described in the literature section and the “doctors at risk” section) as the doctors are not permitted to perform health care services. Therefore they do not act as doctors for the detainees and there is no doctor/patient relationship that can be violated. This argumentation is dangerous. Firstly, it gives doctors permission to participate indirectly in torture. Secondly, it permits doctors to assess the fitness of a prisoner for torture. This is clearly a violation of CAT and the Tokyo Declaration and it is difficult to understand how a western democratic country can accept this.

Classification model

A classification model as a conclusion from the five studies^{6,10,11,14,16} will be described and analysed to determine when doctors are involved in the torture process:

1. Before torture – diagnosis and treatment.
2. During torture – diagnosis, treatment, direct participation and indirect participation.
3. After torture – diagnosis, treatment and falsification of journals, certificates or reports.

Before torture – diagnosis:

- The examination of a prisoner is not illegal or unethical. However it becomes a violation against the CAT,⁹ the Tokyo Declaration²⁸ and the United Nations’ “Principles of Medical Ethics”²⁷ (hereafter referred to as the U.N. Principles) if the findings are used as an argument that the prisoner can “endure” torture (what form of torture and to what degree the prisoner is fit for). This is a doctor’s assessment of torture. It is also a violation if the findings are directly used in a torture session.

Before torture – treatment:

- The treatment of a prisoner is not illegal or unethical. However it becomes a violation against CAT,⁹ the Tokyo Declaration²⁸ and the U.N. Principles²⁷ if the treatment of an existing condition results in the prisoner being ready for torture or more cooperative in torture. It might be considered by the prisoner that the doctor prepared them for torture (see also “During torture – treatment”).

During torture – diagnosis:

- The examination is not illegal or unethical. However, as above, it becomes a problem if the findings are used as an argument that the torture session can continue (to state that their life is not threatened) or if the findings are directly used in the torture session.

During torture – treatment:

- This is not illegal or unethical but, especially in this category, the border can be crossed very quickly. It is a violation against CAT,⁹ the Tokyo Declaration²⁸ and the U.N. Principles²⁷ if a doctor treats a prisoner with the intention of preparing the prisoner for more torture. However some doctors might argue that if the prisoner is in pain, it is their duty to treat the pain, or if the prisoner loses consciousness during a torture session, it is the doctor’s duty to resuscitate the prisoner. Their intention is not to prepare the prisoner for more torture but to act according to the doctor/patient relationship in which the doctor must help their patient. The answer to this dilemma is found in Vesti’s article.¹⁴ Out of the 29 survivors that had experienced doctors’ involvement, 25 persons were tortured, then medically evaluated and then tortured consequent to this. 84% (21 out of 25) of these persons

“did not, either at the time of torture or later, consider the medical evaluation or medical intervention to have been to their benefit.”¹⁴ We do not know from Vesti’s article how many of these medical evaluations or medical interventions occurred with the intention to help the prisoner (according to the doctor/patient relationship) or to prepare the prisoner for torture (it could be exactly 84% of the survivors that a doctor prepared for torture). But the result does give us the answer to our dilemma – whenever doctors are either medically evaluating or medically intervening and this is followed by torture, in the majority of cases it will be experienced by the prisoner/patient that the doctor is not protecting them, and therefore is a participant in administering the torture. Using this argument doctors should not diagnose or treat a prisoner that will later be tortured.

During torture – direct participation:

- This is always illegal and unethical as it is a violation against CAT,⁹ the Tokyo Declaration²⁸ and the U.N. Principles.²⁷

During torture – indirect participation:

- This is always illegal and unethical as it is a violation against CAT,⁹ the Tokyo Declaration²⁸ and the U.N. Principles.²⁷ The knowledge doctors have of anatomy and physiology can be used to create painful torture methods that leave no physical signs or which minimizes the mortality rate.

After torture – diagnosis:

- The examination of a prisoner after torture is not illegal or unethical. However it becomes a violation of CAT,⁹ the Tokyo Declaration²⁸ and the U.N. Principles²⁷ if the doctor examining the torture survivor

suspects that torture has occurred but does not report it.

After torture – treatment:

- The treatment of a torture survivor is not illegal or unethical but not reporting a suspicion that torture has occurred is a violation against CAT,⁹ the Tokyo Declaration²⁸ and the U.N. Principles.²⁷

After torture – falsification of journals, certificates or reports:

- This is always illegal and unethical as it is a violation against CAT,⁹ the Tokyo Declaration²⁸ and the U.N. Principles.²⁷ In this case it is especially forensic scientists that could be involved in torture. Doctors can hide death caused by torture by stating in a death certificate that the person died of natural causes or purposely omit information on the cause of death.

Discussion and analysis of the results of the five studies using the classification model

Smidt-Nielsens’ study¹¹ shows that 9% of torture survivors experienced diagnosis before torture and in Vesti’s study¹⁴ the result is 24%. This difference could be caused by the regional differences of the population groups in the two studies and that Smidt-Nielsen had tougher criteria for the identification of doctors. The statements from interviewees in the AMEDD report⁶ show that 42% of the subpopulation of “doctors” have performed pre-screenings which correlates to 5.2% of the entire population. When the three studies are compared, it shows that in some regions diagnosis before torture is common and both survivors and doctors state that it occurs.

Diagnosis during torture is experienced by 18% (Smidt-Nielsen¹¹), 24% (Rasmussen¹⁰) and 86% (Vesti¹⁴) of torture survivors. The lower result in Smidt-Nielsen’s study

could be due to the demand of visual identification of the doctor. Vesti's result could be higher due to the inclusion criterion that there had to be "signs of physical torture".¹⁴

This could mean that the survivors were more severely tortured because of the physical component, and therefore needed medical evaluation. The results demonstrate that the study¹¹ with the smallest figure shows that almost $\frac{1}{5}$ of the survivors have experienced doctors' diagnosis during torture. When this is compared to more than 9% of the "doctors" in the AMEDD report⁶ stating they have been present during interrogation, it clearly illustrates doctors' involvement in this part of the torture process.

Treatment during torture is seen in 5% of cases in Smidt-Nielsen's study¹¹ and 37% in Rasmussen's.¹⁰ The lower result in Smidt-Nielsen's study¹¹ could again be a reflection of the tougher criteria for the identification of doctors. In all cases in Rasmussen's study,¹⁰ the treatment was administered due to loss of consciousness. This illustrates the severity of the torture. The AMEDD report⁶ shows that the "doctors" were asked if they provided medical care so the interrogation could continue, 1.4% said yes. However it should be taken into consideration that some "doctors" might not have answered this question truthfully, since it is a sensitive subject, and therefore this number could be higher than stated.

Direct participation of doctors in the torture session is described as 22% in Rasmussen's study¹⁰ and 6% in Smidt-Nielsen's.¹¹ From the "doctors'" statements in the AMEDD report⁶ 0.6% participated in interrogation. It has to be criticised that the question given to the "doctors" was if they "*were asked to participate in interrogations*"⁶ and not if they actually *did participate* in the interrogation. "Doctors" may have participated voluntarily and therefore the result does not

rule out that more than 0.6% participated in interrogation. Doctors participating in torture undermines the role of the doctor as one who restores health.

Reis et al¹⁶ show that 5% have performed a non-therapeutic amputation of ears. According to CAT⁹ this is not classified as torture if it is performed as a consequence of "lawful sanctions". If Iraq had this punishment written in the law and the amputation was a result of "lawful sanctions", then by CAT's definition the doctors did not commit torture. The Tokyo Declaration²⁸ on the other hand classifies this as torture. 4% of doctors had killed torture survivors with "mercy bullets". They may argue they did it to end the pain and suffering of their patient. The torture survivor may also believe it is a "friendly" act by a doctor.¹¹ Yet this is a result of very effective torture as the tortured person has been broken. The doctor's role is to provide real treatment and not to "treat" prisoners with death.

Diagnosis after torture is very common; 73% in Rasmussen's study¹⁰ and 94% in Smidt-Nielsen's.¹¹ In the latter study the survivors were examined or treated by doctors so "that torture could resume quickly".¹¹ This is an alarming result that undermines what being a doctor stands for. The 73% in Rasmussen's study¹⁰ are torture survivors examined by doctors, resulting in hospitalisation. It is not clear from the study if the findings were reported. It is also not clear if the survivors were further tortured after their stay in hospital.

In the AMEDD report⁶ 14% of the "doctors" of the subpopulation performed a "post screening". Most of these post screenings were documented,⁶ however it is not clear if suspicious findings (if there were any) were reported. As it was only 1.5% of the entire population of "doctors" that performed this post screening it can not be

considered standard procedure. Post screening could have been performed as a result of a hard interrogation, leaving the detainee in a condition that had to be examined and maybe treated. If this is the case the post screening should have resulted in a report with suspicion of torture. By not doing so the doctor would be complicit in torture and therefore violate CAT.⁹

Reis et al¹⁶ is the only study that provides results of falsification of journals, certificates or reports. 7% of doctors state they have falsified death certificates and 4% have falsified medical-legal reports of alleged torture. It is not clear if this was done once or several times or if it was the same doctors who performed both kinds of falsification. But the results illustrate how doctors hide torture through their work.

As seen in Table 2, none of the five studies^{6, 10, 11, 14, 16} report anything in the categories: “before torture – treatment” or “during torture – indirect participation”, however this does not necessarily mean that doctors do not participate in torture in these ways.

Conclusion

Both torture survivors and doctors state that doctors are involved in torture. Most doctors involved are doctors at risk. Dual loyalty, political initiatives and lack of training in human rights issues are important reasons why doctors participate in torture. Doctors are primarily involved in the diagnosis/medical examination of torture survivors/prisoners, but also in treatment, direct participation and falsification of journals, certificates and reports. More studies with a focus on doctors' involvement in torture are needed to further investigate this subject. Interviews with both detainees/torture survivors and doctors from the same prison/military facility could provide a valuable perspective.

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Doctors in prison: documenting torture in detention

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Keywords: Prison doctors, dual loyalty, custody, trust, documentation

Introduction

The documentation of torture inside a prison raises a certain number of issues specific to the fact that those people interviewed are still in custody. Quite obviously, there will be pitfalls to avoid, and safeguards to ensure, that will not be present when documenting torture within the relative safety and calm of a centre for torture survivors. In a prison, the prisoners who have suffered ill-treatment and torture, are at least potentially still at risk in the sense that they are still in the custody of the authorities responsible for their suffering torture. They are not yet “torture survivors”, but indeed still “torture victims”, however much we may want to get away from the stigma of this term. This essential fact, the prisoners not yet being “home free”, as they may well be in a torture rehabilitation centre abroad or at least out of reach of the potential torturers, will condition the way doctors document ill-treatment and torture inside prisons and other places of custody.

When prisoners are seen outside prison, in a rehabilitation centre or similar situation for example, the documentation of torture will be a completely different story. Such centres will hopefully offer ideal conditions for medically examining torture survivors and documenting torture. These centres have trained medical staff, with the necessary medical and psychological skills and knowledge who can provide therapy. Most important, there may be few, if any, time limitations for interviews, and repetition of interviews according to need and desire will be the rule, not the exception. The doctor-patient relationship in a therapeutic centre will obviously be completely different from that between a prisoner in custody and, on the one hand, the local “prison doctor”, or, on the other hand, a visiting outside doctor.

Doctors in prison: which doctors are we talking about?

The first point which must be addressed is exactly which type of doctor one is talking about in this paper, regarding the documentation of torture. A doctor in a prison can be the one who is part of the custodial system, paid by the authorities and thus seen by the prisoner as being “on the other side of the bars” by the prisoners. Such a doctor is perceived very differently, and is indeed in a totally different situation, from

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a doctor coming to the prison from the outside world, quite possibly even from an outside country.

As shall be discussed in more detail further on, the “prison system doctor” is in a situation of dual loyalties in the best of cases. As doctor of a prison system, s/he works within a system that demands loyalty and submission to certain constraints, while at the same time, s/he works with prisoners who are patients, and to whom the doctor owes loyalty as a physician within the “doctor-patient relationship”. The submission to constraints may be benign – concerning only obvious factors linked to security and to the fact that quite obviously prisoners lose many privileges and rights by the very fact that they are in custody.

However, as the issue is that of “documenting torture”, there may be very more complex and even dangerous situations to be considered. If torture exists in a given country (justifying the need for documentation in the first place), this means there is a system in place, or at least condoned, by a higher authority. The prison doctor, in the worst of cases, may be part and parcel of that coercive system, thus ending any discussion of documentation by the doctor. In a better case, torture may exist, but the prison system be outside of it, as is often the case when torture is practiced by the armed forces or security police, and not at all inside the prisons.

In the latter case, a prison doctor may well see the need to document the sequelae of torture, and thus may decide to take the risk of doing so. It should be obvious that such a doctor will nevertheless be putting him or herself at risk, as there may be very few mechanisms available to offer him or her any protection.

The other case is very different, that of a doctor coming in from the outside to docu-

ment torture inside prisons. The very fact that an outside medical expert is allowed into a prison already in a way guarantees the outside doctor’s physical “safety”. Otherwise it would be more simple just to refuse entry into the prison. This relative safety will allow the outside doctor to work, but s/he needs to be very specific about *how* the documentation will be done, so as not to put the prisoners interviewed in danger.

Thus, one has two completely different situations of doctors documenting torture. Paradoxically, what is often perceived as the most difficult part of documentation, i.e. objectively assessing signs and symptoms, is in fact the common ground that these two types of doctors have. Both can study and use the information given in the body of the “Istanbul Protocol” once they have decided to go ahead to interview and examine prisoners.

The prison doctor

Doctors working inside prisons confronted with the issue of torture can be in two very different scenarios. In the first case, the detainees or prisoners (the difference depends on whether they have been sentenced or not) have been tortured *before* arrival in the prison. This means torture has occurred either upon their arrest, or during the interrogation procedures, or in a different place of custody, very often a “secret one”. In the first case scenario, torture does not occur in the prison where the doctor actually works as a doctor. The second scenario will be the case where torture actually occurs inside the prison where the doctor is working as a prison doctor. This second scenario will of course put the doctor in a much more complicated situation.

Prison doctors will often not have the trust of the prisoners in their care, all the more so if the prisoners have been tortured

by the very authorities the prison system represents. Such prisoners will more often than not see the prison doctor as part of the coercive system. This will be all the more so if other doctors have actually been present or participated in coercive torture sessions. The fact that doctors may have participated in the system of repression will result in prison doctors being assimilated into the general repressive regime. In other contexts, where torture is exclusively practiced by a non-custodial body such as the police, prisoners may acknowledge that once they are in a prison the prison staff, including doctors, is not involved in harassing them nor continuing the repression. In such cases, the prison doctors may be seen with at least some degree of sympathy, and prisoners may put some trust in them.

Documenting torture is a very difficult matter with prisoners still in custody. They are still vulnerable, and often extremely so.

For a prison doctor the most important factor in documenting torture will be obtaining the trust of the prisoners, without which any objective documentation will be impossible. However, even if good communication is somehow achieved between prisoners who have been tortured and a prison doctor with integrity who wants to document torture, there are other problems to consider.

The main purpose of seeking documentation of torture would surely be to draw up a file of information to be submitted to some higher authority, in the endeavor of putting a stop to the taking place of torture. This very fact, obtaining data and putting it down on paper or otherwise, will already introduce several risk factors which any doctor must assess before actually going ahead with documentation.

Documentation of torture in a country where torture takes place may well put both documenter and documentees at risk. There

may be a risk for the doctor who is seen as collecting information which might be used to incriminate perpetrators of torture or their superiors who have authorized its use. A prison doctor must consequently be very aware of the possible risk s/he may be taking. Even more important, the risk to the prisoners, whose trust s/he must obtain, and who will provide information on torture, needs also to be assessed.

Documenting torture should never become an absolute objective in itself. The principle to constantly keep in mind is "primum non nocere", one of the four main principles of medical ethics, i.e. that of non-maleficence. Even in the general interest of combating torture, apart from protecting themselves, doctors have to be absolutely sure that there will be no reprisals on those persons whom they speak to and who will have give not only their testimonies, but also their trust, within the medical consultation. Unless the prison doctor is certain s/he can guarantee the safety of any prisoner interviewed, documentation should not be pursued.

When documenting torture in such a situation, there will be pitfalls to be avoided. These concern the working methodology and actual documentation procedures.

One major issue that may seem obvious to medical staff working in rehabilitation centre for victims of torture, but may not be self-evident to run-of-the-mill prison doctors, is that prisoners who have been tortured should never be *forced to* "relive" their torture experience by having to tell their stories to interviewers, i.e. forced to undergo "retraumatization" during the documentation of torture. Well-meaning prison doctors, having been trained in the signs and symptoms of torture, may be all too eager to "get documentation" ... The risk of opening a prisoner's "Pandora's Box" of retraumatiza-

tion is very real. What is meant by the term Pandora's box, is a whole "collection" of thoughts and memories, many terrible, and all traumatic, involving the personal torture history of each prisoner. These recollections can be varied according to contexts and situations, and of course individual vulnerabilities. A prisoner may finally have achieved "locking up" such memories, flashbacks, nightmares, and other traumatic experiences, so to say in a "box" which is still ever-present, but closed. As in the legend of Pandora, the opening of that box will release demons and devils, and all the coping mechanisms the prisoner may have painfully put together are rent asunder by the well-meaning good intentions of the person eager to get documentation ...

Establishing trust between the prison doctor and the prisoner

This key issue of trust will be a crucial issue in most contexts. Prison doctors almost always work for a prison administration, under the responsibility of the Interior or Justice Ministries. It is very rare to have the prison medical service entirely independent from the prison administration. This is the case in a mere handful of countries, mainly in Europe, where the prison doctors work for the Ministry of Health, and are "on loan", so to say, to the prisons.

This situation, as has been mentioned, means that prisoners see the prison doctor as "part of the system", and prison doctors do have to "split" their loyalties between the prison service and the patient. This can turn out to be a major dilemma. In countries where torture takes place, it may be difficult or quite impossible for a doctor to act freely and start to investigate and document cases of torture. In the ICRC experience, prison doctors in countries that torture most often prefer to "look the other way" when prison-

ers have complaints or symptoms that could possibly be related to torture.

In some countries torture may not only be present, but actually rampant, and evidence of it readily available. For example, there may be medical articles which describe cases of renal insufficiency secondary to massive beatings or crush-syndrome. Prison doctors in such countries will however be extremely reluctant even to consider talking about such cases, let alone go out on a limb and document even the obvious ... In a country that tortures, such doctors will have legitimate concerns or fears for their lives or that of their families, and one can understand their reluctance.

From the prisoners' point of view, they may be reluctant to talk about their torture experience to the prison doctor for two different reasons. First of all, as has been said, it is the overall context of the situation in the country. The fear not only for themselves but also for their families. This will often make prisoners hesitant to consult the prison doctor about any sequelae of torture. Rightly or wrongly, they will fear reprisals for "having complained" about it. Second, torture by its very nature is a subject that prisoners do not broach easily. It involves the infliction not only of pain and suffering, but also of humiliating and degrading practices, which prisoners understandably will have great difficulties speaking about.

Even in the case of prisoners having visible scars of brutal torture on their bodies, they will often be very reluctant to saying anything about it out of fear of reprisals. Informed consent should be a "sine qua non" condition for using any of the information about torture provided by prisoners during interviews. A prison doctor may need to keep any information s/he has gathered "in secret", until the overall situation changes and only then bring it out when there is no

longer any risk either to doctor or prisoners.

The case of visits by an outside doctor to document torture

The main aim of visits to prisoners by outside bodies, such as the Council of Europe CPT, the UN Special Rapporteur on Torture, or the International Committee of the Red Cross, is to document torture. However, it should not be forgotten that there are other issues concerning prisoners that also will need to be part of the overall approach to violations of human rights or of International humanitarian law. Prison conditions for example, may be unsatisfactory, but not be part and parcel of an actual system of torture.

When torture is the issue, the aim is to obtain concrete information about methods and circumstances of torture and about the effects and durable sequelae of torture on the persons who have suffered it. This will allow outside bodies or governments to exert influence upon the perpetrators, the ultimate aim being to put a stop to the practice of torture.

Doctors coming from the outside who document torture will normally not start with the handicap of mistrust that confronts even the most well-meaning prison doctor. The outside doctor will have to know exactly what his/her terms of reference are, and then only accept to interview prisoners if it is certain within reasonable doubt that no one will suffer reprisals or punishments for having spoken out. It is essential that any prisoner interviewed is seen *in private* by the interviewing doctor. In private means not only without the presence of custodial staff, but also without any other presence, particularly of fellow inmates.

It is only through the safeguard of having interviews in private that prisoners may

decide it is safe for them speak freely and divulge information about torture. Prisoners may also, very understandably, desire privacy for personal reasons, as torture can raise a series of very intimate matters that prisoners may want to keep private. In all cases the interviewing doctor should explain the doctor-patient relationship and tell the prisoner that anything said or found upon medical examination will not be divulged without the prisoner's informed consent.

General considerations about the "torture interview"

The way to document torture will vary considerably according to the person having been subjected to torture. An interview with a political activist or political prisoner will be very different from that with a simple farmer caught up in a war situation, or from a very sensitive interview with a young woman having been tortured and raped by her oppressors. Documentation will also vary according to context, to the religious background of the victims, and according to what methods are used. The Istanbul protocol goes through the many forms torture may take, describing methods and sequelae in great detail. There are, however, general considerations concerning any interview with a victim or survivor of torture, which doctors, prison and outside, will need to consider at all times.

– It cannot be repeated enough that *empathy*, real and not merely formal and institutional, is a paramount condition for anyone working with victims of torture. "Doing no harm" may mean, in some cases, putting down one's pen and paper and merely listening to the victim's story, in cases where direct and full attention is required and when it becomes obvious that the victim feels uncomfortable with what resembles an "interrogation"... Interviewers should never take the risk of enhancing the

injuries of torture by uncalled for assertiveness or aggressive interviewing. The persons interviewed should never feel they are being obliged to talk about their torture experience. It cannot be stressed often enough that a humane approach is even more important, from a humanitarian point of view, than actual documentation.

– It must be repeated that informed consent has to be obtained at the start of any interview for the documentation of torture. It would be unethical to obtain information about torture “at any price”, putting the prisoner at risk because he or she has confided in the prison doctor or outside doctor. The attitude “one cannot make an omelet without breaking some eggs” is absolutely not acceptable.

– Care should be taken to distinguish between the “veteran” political prisoner, who may be more “resistant” to torture and more willing to talk about it and answer specific questions, and the “bystanders” caught up in a situation they are in no way prepared for, and who are understandably more traumatized. More care may be necessary in interviews with the latter category, as they have been totally unprepared for the trauma of torture and its effects.

– Torture victims, as has been said, may have difficulties telling their stories. This may be for a number of reasons: cultural or religious taboos, feelings of guilt and/or shame, psychological defence mechanisms, impairment of memory, and not the least being fear and distrust regarding the visitors. The doctor will therefore need to guide the victim along (“guide” and not “direct”...) and determine which mechanism is in play so as to handle these difficulties. It is most important to have some knowledge about the context. Here the local prison doctor will have a distinct advantage over the expatriate doctor. It is even more important to *listen* to

the interviewee. This should not, however, lead to pre-conceived categorizations of torture. The doctor should approach torture and its consequences as a whole, and not reduce the information received to groupings of methods and medicalised symptoms.

– The outside doctor will have many other disadvantages compared to the local doctor, as the questions to ask will vary greatly from context to context. Chronology may not be in itself crucial to the issue at hand, as often it is difficult for a prisoner to determine the lapses of time. The description of what happened and how it was perceived and “what happened next” may be more relevant to the story. Here, local knowledge may often be a key factor in understanding exactly what happened.

– The actual structuring of the interview will depend greatly on the context and on the personal situation of each prisoner. Obviously, directed questions should be avoided (“Were you tortured when they arrested you?”) in favour of open, general questions (“When you were arrested, how did it go?”, “What happened then?”).

Gender issues and torture

The issue of gender will have greater or lesser importance according to the context. In countries where men and women can exchange conversations without any hesitation, and where female doctors as well as male doctors work interchangeably with either gender, this should be less of a problem. This, of course, by no means rules out individual problems that may arise, as torture by its very nature is meant to humiliate and degrade those submitted to it. Furthermore, medical examinations may be simply out of the question, or at least very uncomfortable, when there is a gender difference between doctor and prisoner. This applies even more particularly to all forms of sexual torture, or

any torture targeting the genitals. Outside doctors will need to consider these gender sensitivities and take them into account at all times.

In conclusion

The documentation of torture by doctors is not an easy task. Documentation of torture in prisons will be most relevant in countries where torture is actually used. There will therefore always be a certain risk to prisoners who are interviewed, and this should be very seriously considered before any documentation is carried out.

A local prison doctor will have experienced many difficulties that an outside doctor will not have, mainly in getting prisoners to trust him or her. Prison doctors are, sometimes rightly but very often wrongly, seen as part of the system of repression. It will be up to the doctor to obtain the merited trust of the prisoners s/he wishes to interview.

An outside doctor may not be at risk him/herself when documenting torture, but the risks for the prisoners will be the same, if not worse, if precautions are not taken to avoid reprisals. Specific modalities ensuring a proper “doctor-patient relationship” should be required before starting documentation, and private interviews with each prisoner should be guaranteed.

Appendix

This appendix supplements the articles given above regarding health professionals' participation in interrogations that violate national as well as international laws.

The appendix consists of

1. An introduction
2. A letter to the American Psychological Association (APA)
3. The answer from APA
4. A response to the APA from a member from APA

1. Introduction

Since the advent of the so-called “war on terrorism”, there has been ongoing scrutiny of the role that health professionals have played in coercive interrogations that, in some instances, have amounted to torture. In the past few years, many health professional associations have issued directives to their members stressing the illegality of torture and the responsibility of their members to document and report incidences of torture.

One group that has been weighing this issue is the American Psychological Association (APA), following evidence that psychologists actively participated in coercive interrogations at U.S. “war on terror” detention facilities. While the APA issued a referendum condemning torture, many members found caveats in the language and felt the association could do more to bar members from taking part in interrogations at such facilities. Earlier this year, APA members proposed a new resolution that would pro-

hibit their members from participating in interrogations that occur at sites which do not meet standards for detention under international law.

The IRCT sent a letter to the APA in August 2008, stressing the importance of closing any remaining loopholes in its anti-torture referendum and encouraging APA members to vote in favour of the proposed resolution. The APA responded to the IRCT by noting that amendments to its previous anti-torture resolution had addressed some of the IRCT’s concerns; the APA also stressed its commitment to pursue investigations against any member alleged to have violated its ethical standards. In September 2008, the proposed resolution passed. Despite this positive development, as member Stephen Soldz points out, concerns still remain – not only about when the resolution takes effect, but also about the APA’s willingness to open investigations against members alleged to have participated in interrogations that constituted torture. The following correspondence tracks this issue in more detail.

Brandy Bauer

2. A letter to the American Psychological Association (APA)

August 22, 2008

Dear President Kazdin and APA members,

The International Rehabilitation Council for Torture Victims (IRCT) would like take the opportunity to address APA members on the role of psychologists in preventing torture and share our ideas of how the APA can move forward to ensure that its members practice their profession under the highest ethical standards.

As an umbrella organisation representing 139 torture rehabilitation centres and programmes in 70 countries, the IRCT understands the devastating impact of torture on survivors. Its consequences include not only physical effects such as long-lasting pain, but psychological sequelae – e.g. PTSD, anxiety and depression. The work of the IRCT and its member centres is to alleviate that suffering and work for the prevention of torture worldwide.

The IRCT is acutely aware that health professionals have participated, and continue to participate, in interrogations that violate national and international laws. For example, IRCT physicians played a key role in investigating and documenting the torture of 11 ex-detainees held in U.S. custody abroad, the findings of which were published in the Physicians for Human Rights report *Broken Laws, Broken Lives*. During their clinical interviews with the 11 men, these physicians learned that not only were health professionals present during torture and ill-treatment and failed to report the abuse, they also gave confidential information to interrogators and

in some instances even denied medical care for the detainees. And just one week ago, lawyers for Guantanamo detainee Mohamed Jawad charged that a psychologist's report filed at the detention facility led to the then-teenager being placed in isolation, resulting in a deterioration of his mental health.¹ Such actions flagrantly violate the fundamental ethical precept of the health professions to "do no harm".

Last year, the APA passed a resolution condemning and prohibiting psychologists' participation in interrogation that involves torture and other cruel, inhuman or degrading treatment. While the resolution represented a step forward in preventing torture and ill-treatment, on 4 September 2007 the IRCT issued a statement² expressing concern about the qualifiers in the resolution in respect to the scope of definition of the techniques it mentions.

These concerns still stand. The IRCT thus reiterates that all of the listed techniques are illegal and unethical in all circumstances and not only when "used in a manner that represents significant pain or suffering or in a manner that a reasonable person would judge to cause lasting harm" as stated in the resolution. Moreover, we repeat our concern that the resolution adopts the United States' reservations to the United Nations Convention Against Torture, which weakens the Convention by narrowing its definition of torture with regard to mental pain or suffering.

The IRCT is aware that APA members are currently voting on another resolution that would put a moratorium on members'

1) The psychologist in question has invoked Article 31 of the Uniform Code of Military Justice so as not to be self-incriminated. For more information see: www.nytimes.com/2008/08/16/washington/16psych.html?ref=health

2) See www.irct.org/Default.aspx?ID=159&M=News&PID=5&NewsID=954

participation in military and CIA interrogations altogether. Given the abuses that have taken place in US-run detention centres around the world in later years and the ambiguities that the present US administration has sown with regard to the absolute prohibition against torture and ill-treatment, the IRCT finds such a moratorium appropriate. Therefore we strongly urge APA members to vote “yes” on the proposed resolution.

As several APA members have noted, this resolution is intended to put an end to psychologists’ participation in interrogations that occur in settings that violate international justice and humanitarian standards; it would not prohibit psychologists from working in settings that uphold international and human rights law. The IRCT believes that the APA has the ability to set a precedent for mental health professionals worldwide. The profession of psychology already has suffered ethical damage through its association with the “war on terror” – it will take much time and effort to recover, but the passage of this resolution would be an important step toward healing.

Sincerely,
 Brita Sydhoff
 IRCT Secretary-General

Jose Quiroga
 IRCT Vice President and Representative of
 North America Region

3. The answer from APA

Dear Ms. Sydhoff:

I am writing in response to your Aug. 22 letter to our president, Alan Kazdin, and members.

I believe that the American Psychological Association’s Council of Representatives addressed some of the concerns you expressed. You appear to be unaware that the Council passed an amendment to its August 2007 anti-torture resolution eliminating the phrase when “used in a manner that represents significant pain or suffering or in a manner that a reasonable person would judge to cause lasting harm.” The new paragraph reads:

BE IT RESOLVED that this unequivocal condemnation includes all techniques considered torture or cruel, inhuman or degrading treatment or punishment under the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; the Geneva Conventions; the 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; the Basic Principles for the Treatment of Prisoners; or the World Medical Association Declaration of Tokyo. An absolute prohibition against the following techniques therefore arises from, is understood in the context of, and is interpreted according to these texts: mock executions; water-boarding or any other form of simulated drowning or suffocation; sexual humiliation; rape; cultural or religious humiliation; exploitation of fears, phobias or psychopathology; induced hypothermia; the use of psychotropic drugs or mind-altering substances; hooding; forced nakedness; stress positions;

the use of dogs to threaten or intimidate; physical assault including slapping or shaking; exposure to extreme heat or cold; threats of harm or death; isolation; sensory deprivation and over-stimulation; sleep deprivation; or the threatened use of any of the above techniques to an individual or to members of an individual's family. Psychologists are absolutely prohibited from knowingly planning, designing, participating in or assisting in the use of all condemned techniques at any time and may not enlist others to employ these techniques in order to circumvent this resolution's prohibition.

The American Psychological Association is deeply concerned about the recently alleged involvement of a psychologist in an abusive interrogation of a Guantanamo detainee. While the psychologist who has been named is not an APA member, the Association's position is steadfast. No psychologist – APA member or not – should be directly or indirectly involved in any form of detention or interrogation that could lead to psychological or physical harm to a detainee. Doing so would be a clear violation of the profession's ethical standards.

APA strongly supports the full implementation of the U.S. Supreme Court decision holding that Guantanamo detainees have a constitutional right to judicial review of their detentions. We are closely monitoring all available information relevant to the role of psychologists in detainee treatment. APA will pursue ethics investigations where evidence indicates that an APA member has violated our ethical standards.

Finally, with regard to the referendum before our membership, the balloting period closes on Sept. 15, after which an independent firm will tally the votes. We will make the results public as promptly as possible.

Thank you for your letter, and for your

efforts to work for the prevention of torture worldwide. Please do not hesitate to contact us if you would like more information.

Sincerely,
Kim I. Mills
Associate Executive Director
Public & Member Communications

4. A response to the APA from a member from APA

The American Psychological Association and Abusive Detention Center Policy: Progress Despite Stiff Opposition

Stephen Soldz, Director*

The American Psychological Association's (APA) letter responding to the IRCT suggests that APA has consistently been concerned about U.S. psychologists' contributions to the U.S. governments' systematic program of torture and detainee abuse.¹⁻⁵ Unfortunately, the historical record reveals that, contrary to this picture, the APA has consistently downplayed psychologists' contributions to detainee abuse and exerted great efforts to keep psychologists in the abusive U.S. detention facilities, such as Guantanamo and the CIA's "black sites". Over the many years of the Bush administration program of abuse the APA has passed several anti-torture resolutions⁶⁻⁸ while never questioning their "policy of engagement" that insisted that psychologists, rather than aiding abuse, were instead helping to keep interrogations "safe and ethical".⁹⁻¹⁶ Critics among the association's membership have dissented from¹⁷⁻²⁵ and fought for years to change these policies.²⁶⁻²⁸

This fall, the movement against psychologist participation in U.S. torture and detainee abuse experienced a significant victory. The members of the APA rejected the policies of the association's leadership. By a vote of 59%, the members passed a referendum stating that APA members may not work in U.S. detention centers – such

as Guantanamo or the CIA's secret "black sites" – that are outside of or in violation of international law or the U.S. Constitution "unless they are working directly for the persons being detained or for an independent third party working to protect human rights".²⁹ Passage of this referendum is a significant milestone in a years-long effort by activist psychologists to change policies that encouraged participation in detainee interrogations.

After years of failing to effect real change through the associations' Council of Representatives – which infrequently challenges the APA leadership on issues of vital importance to those leaders³⁰ – dissident members and allies turned in 2008 to new strategies designed simultaneously to take advantage of, and to bypass, the official structures. Members of the WithholdAPAdues³¹ group found a never before used provision in the association by-laws allowing for a member-initiated policy referendum. Three psychologists – Dan Aalbers, Brad Olson, and Ruth Fallenbaum – wrote a referendum statement rejecting the participation of psychologists at detention centers operating outside of (as in the Geneva Conventions don't apply) or in violation of (as in enhanced interrogations are approved) international law or the Constitution.

The campaign generated amazing grassroots activism. People never before heard from were emailing their successes in convincing other colleagues to vote. Psychologists for Social Responsibility and others made brief videos distributed on YouTube and Google Video. Two APA divisions lined up in support. Conversation about the referendum on psychologist-run listservs was greater than that on any other topic in memory.

Referendum passage constitutes a giant step forward for those psychologists

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who have been fighting to change the APA's policies on involvement in the detention centers. But the struggle of these activist psychologists is far from over. First, there is a disagreement with APA leadership as to when the policy change goes into effect; the leadership claimed initially that the bylaws state that the change doesn't go into effect till next August, while referendum supporters believe this claim is an egregious misreading of the bylaws. Discussions continue regarding the details of referendum implementation. To his great credit, APA President Alan Kazdin skirted the areas of disagreement, allowing him to promptly write President Bush and U.S. Defense Secretary Robert Gates, informing them of the new association policy.³²

Moreover, while the APA's policy is in the process of changing, the organizational and policy conditions – the culture that allowed the APA to advocate for years in support of psychologist participation in detainee interrogations – have not changed. Activists are focused upon several additional steps to bring about a rejuvenation of their association and their profession.

There is a strong campaign afoot to elect one of the activists as APA President to make sure the new policy is firmly implemented and backed by the organization, as well as to push other efforts making human rights and social justice more central within the profession of psychology. Steven Reiser, a New York psychologist is running an active campaign.²⁷ In the first nomination phase of the campaign, he received the highest number of votes among the five winning candidates. Passage of the referendum should provide an even stronger boost to his campaign. Ballots went out to the APA membership this October and are due back December 1.

APA members have been deeply dis-

turbed by another prior action of the Association. In 2002, its ethics committee placed a clause (1.02) in the ethics code allowing laws, regulations, and government orders to override professional ethics.³³ These members are concerned that the clause provides an offensive loophole that is a variation on the Nuremberg defense – “I was just following orders” – into the ethics code.³⁴

As far back as 2005, the APA Council of Representatives called on the ethics committee to develop a plan to revise this clause. Despite these instructions, the association has resisted clarifying this clause by adding a phrase as simple as “except when violating fundamental human rights”. Other disturbing 2002 modifications to the APA ethics code weakened protections for research participants, such as removing a requirement for informed consent from participants “where otherwise permitted by law or federal or institutional regulations.” Such a clause could, for example, allow experimentation on detainees without their permission, a disturbing violation of professional guidelines and international agreements.

Also added in 2002, section 8.07 on deception in research permits too high a threshold for allowable deception research: “Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.” The phrase “severe emotional pain” – changed from “unpleasant emotional experiences” – was added in 2002. It eerily echoes the definition of psychological torture in the UN Convention against Torture:³⁵ “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person ...” Surely a research procedure should not need to meet the legal definition of “torture” for disqualification as an ethics violation.

In its response to the IRCT, the APA states that “[w]e are closely monitoring all available information relevant to the role of psychologists in detainee treatment. APA will pursue ethics investigations where evidence indicates that an APA member has violated our ethical standards”.³⁶ While some psychologists, including APA members, have been documented to have participated in abuses likely constituting torture, the APA ethics committee has consistently stalled action against³⁷ or refused to open cases against these psychologists. The ethics committee has even engaged in such petty actions as refusing to accept a web address (URL) for documents from the Senate Armed Services Committee, insisting that the complainant print out and submit them in hard copy.

In the case of Col. Larry James, head of the Behavioral Science Consultation team at Guantanamo from January till May 2003,³⁸ the association has not only refused to open a case in response to an ethics complaint, but Col. James has since been elected president of one APA division (military psychology) and awarded a prestigious award by another.³⁹ There is no evidence of the APA initiating any investigation without prompting from members. Rather, APA leadership has consistently denied or minimized psychologists’ potential contributions to detainee abuse.^{40,41,30} The APA is far from demonstrating its seriousness in pursuing ethics investigations.

Another form of accountability is a “setting right” of the historical record. Given the known facts regarding psychologists and their roles in detainee abuse, and given the extensive downplaying and denial of these facts and their significance by APA leadership, it is critical to create a detailed public record of the contributions of psychologists to the dark side over the last seven years. It

is imperative that a truth process be created that will examine all materials, existing in the public record or available through investigation, and construct such a permanent record. Also necessary is a careful examination of the many other organizational, ethical, and policy issues that allowed the psychological profession and its major professional organization to become complicit in detainee abuse over the last seven years. Preferably, this process would be part of a Health Professionals Truth Commission examining the roles of members of all health professionals in U.S. detainee abuse, as members of all these professions abetted this abuse.⁴²⁻⁴⁵

One possibility is that such a Commission could be a subcommittee of a Congressionally-chartered Truth Commission on detainee abuse under a new U.S. administration. Another possibility is that prominent psychologists along with such organizations as Psychologists for Social Responsibility, Physicians for Human Rights, Physicians for Social Responsibility, and the IRCT could create such a Commission. Clinical psychologists often encourage their clients to face harsh truths. It is similarly necessary for our profession to face these somewhat cold and difficult realities. Only this will prevent us from recreating this sad episode in our profession’s history when the next national or international crisis hits.

The implications of passage of the referendum extend beyond the APA and psychology. The referendum will put additional pressure on the Defense Department to remove psychologists from their roles aiding interrogations and detainee behavior management. It will also create additional pressure for the development of a mental health system for detainees that is completely isolated from chain of command pressures. While the U.S. Department of

Defence is not necessarily bound by APA policy, it generally follows professional ethics policies; to do otherwise could make its efforts to recruit and retain psychologists and other professionals substantially more difficult. The implications for the CIA's "enhanced interrogation" program are less certain, given the secrecy under which that program is conducted. Yet, even there, the APA referendum will increase pressure for a new administration and Congress to shut down the program.

Finally, passage of the referendum is being heralded by the wider public as a sign of an impending rejection by U.S. citizens of the "dark side" which has taken over so much of our government and country in recent years. This feeling was expressed by the conservative commentator, anti-torture activist, and blogger Andrew Sullivan who headlined his posting on the referendum's passage with "Know Hope." Congratulatory emails from around the world have indicated that many find hope in our psychologist colleagues' rejection of the dark side. "Finally, good news from the U.S." one email said. These correspondents join us in hoping that this rejection of official torture and abuse will be followed by a wholesale rejection from the American public and government.

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