

preventing torture

The role of physicians and their
professional organisations:
principles and practice

This report considers how professional medical bodies can more effectively work towards eliminating torture, both through the support they give their members, and in their response to medical complicity. In order to build on experience we include five case studies from the United States, Sri Lanka, the United Kingdom, Italy and Israel. These studies are in no way globally representative and we see this report as an invitation to contribute others. We conclude with recommendations for National Medical Associations and for the World Medical Association. There is clear evidence that there is still much to be done both to protect medical professionals who expose torture, and to prevent medical complicity in it. This report is part of a ‘work in progress’ to address this unacceptable situation.

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Introduction

Societies emerging from the aftermath of World War 2 and the Nuremberg trials looked optimistically to the 21st Century – with the prospect of an effective United Nations – as heralding a new era of human rights; yet even before the end of that century’s first decade, allegations of torture were substantiated in countries that were previously considered to be leading respecters of human rights. In his autobiography ‘Decision Points’, published in November 2010, George W Bush defended his decision to sanction ‘waterboarding’ in 2003 on the basis that ‘I am not a lawyer’, and justified it by claiming that it had saved lives in America and in London, quite ignoring other legal opinions, the well-established unreliability of evidence revealed under duress, the doubts cast on its value by UK Government spokespersons and the banning of such practices by Barack Obama on the second day of his presidential office.¹

Medical complicity in torture occurs when physicians willingly take part in, facilitate, or allow torture by failing to report clinical evidence of torture to relevant authorities.² However there are also numerous instances of medical professionals who, often at personal risk, seek to prevent and mitigate the effects of torture. It is important that when they do, they receive the support and protection they need.

The leadership, support, regulation and censure offered by National Medical Associations (NMAs) and their umbrella body the World Medical Association (WMA), and by related professional and UN human rights bodies, are key both to preventing medical complicity and torture, and to providing support to medical professionals who try to prevent it.

This report considers how professional medical bodies can better respond to medical complicity in torture and support members in preventing both complicity and torture itself. Previous reports have tended to focus on single countries and NMAs, so we felt it more important first to explore the pertinent general principles. In doing so we recognise that different NMAs have different roles and responsibilities. The Israel Medical Association, for example, combines the functions represented in the UK by the British Medical Association (BMA), a voluntary association of doctors, and the UK General

Medical Council (GMC), the statutory body for the compulsory registration of medical doctors which has disciplinary powers. Some of the recommendations that conclude this report are therefore of a general nature, although based on considerations of experiences from various countries.

To build on actual experience the general introduction is followed by five national case studies from the United States, Sri Lanka, the United Kingdom, Italy and Israel.

These case studies are clearly not in any way globally representative, nor are they intended to be. Rather, we see this report as the start of a process that we have begun by gathering accurate, well-researched case studies from health professionals who are known to us, who are either based in the countries they write about, or who have expert knowledge of those countries. The case studies were selected on the basis of knowing potential authors. They are not intended to represent any particular group, cross section or sample. There are huge variations in the availability of information, the existence and strength of professional bodies and the ability of health professionals to speak out about torture in different countries. We anticipate the process that we have initiated continuing with the addition of other case studies in the future.

It is worth mentioning a few other issues and examples not covered by the case studies:

Collaboration with human rights organisations is essential.

In this respect the publication of the report ‘*Documenting the crime of torture in the Palestinian Territories*’ (December 2010) by the Arab Organisation for Human Rights in the UK in association with the Middle East Monitor, is an example. This illustrated report refers several times to medical staff – not just in Palestine but also in Jordan – examining patients clearly undergoing torture yet making no effective report to any authority.

Doctors and other professionals working with torture victims in difficult environments can make valuable contributions to training in the diagnosis of

1 Siddique & McGreal (2010) Waterboarding is Torture, Downing Street confirms. The Guardian November 9th 2010. <http://www.guardian.co.uk/world/2010/nov/09/george-bush-memoirs-waterboarding> accessed 11 03 2011

2 World Medical Association (adopted 1975) WMA Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment <http://www.wma.net/en/30publications/10policies/c18/index.html> accessed 11 03 11

torture and this can be of benefit internationally.

Turkish doctors – in particular the team led by Dr Sema Piskinsut – played a key role in the exposure of torture in Turkey in the late 1990s and early 2000s. In 2009 a comprehensive and illustrated *‘Atlas of Torture’* was produced by a group of health specialists, including physicians, with the aim of ensuring that doctors had effective training in the recognition of torture. This was translated into English in 2010.³

Physicians can come under great pressure during investigations, and professional bodies could and should play a key supportive role when this happens.

An extreme and unresolved example of this is the death of Dr Ramin Pourandarjani, a 26-year-old Iranian doctor who was giving evidence to Iran’s parliament as part of an investigation into deaths at the Kahrizak detention centre in late 2009. He reportedly spoke to Iranian MPs of the torture he had seen shortly before he died suddenly and in unexplained circumstances.⁴ Prior to this, it is reported that he had come under great pressure to say that one of these patients had died of meningitis.⁵

In recent years, the ‘ticking bomb’ scenario, featured in various films and fictional settings, has been used in defence of torture.

The ‘ticking bomb’ scenario is a hypothetical situation in which a detainee is thought to know about, but refuses to divulge, an imminent action

which puts innocent lives at risk. It is frequently cited in an attempt to defend an ultimate option to torture. Apparently first described in a French novel in 1960, it has also been described as a ‘thought experiment’. It is based unrealistically on a range of narrow assumptions, ignores all except one possible outcome, and opens up an inevitable ‘slippery slope’ to a greater use of torture in ever wider circumstances.⁶ Despite this senior American jurists such as Alan Dershowitz and Richard Posner have defended it as a justification for torture and former US Vice President Dick Cheney claimed that torture applied in this situation has saved lives.⁷ Even if a ‘ticking bomb’ scenario could occur, there can never be any justification for the use of torture, which includes ‘moderate physical pressure’, or the involvement of medical professionals in its use.

The aim of this report is to contribute to the process of strengthening professional bodies and related organisations in both opposing medical complicity in torture, and supporting medical professionals in its prevention and mitigation. It is also an invitation for others to take up individual national case studies to this end, and to consider how the recommendations in this report can be applied in each context.

We also recognise that health professionals are just one of the groups relevant to the prevention of torture, and that collaboration with other groups is essential. An inspiring example of this was the March 2010 meeting on the role of health professionals in documenting torture, organised as a side event at the 13th session of the UN Human Rights Council by the World Medical Association and the International Rehabilitation Council for Torture Victims (IRCT).

3 Ozkalipci et al (2010) *Atlas of Torture: use of Medical and diagnostic examination results in medical assessment of torture*. Human Rights Foundation of Turkey ISBN 978-975-7217-76-3

4 Moszynski P (2009) Doctor died while assisting inquiry into deaths in Iranian detention centre *British Medical Journal* 2009; 339:b5673

5 Tait R (2009) Death of doctor to Iranian prison arouses suspicion. *The Guardian* 16 November 2009. <http://www.guardian.co.uk/world/2009/nov/16/iran-protest-doctor-pourandarjani-death> accessed 11 03 2011

6 Association for the Prevention of Torture (2007) *Defusing the Ticking Bomb Scenario: Why we must say No to torture, always*. Association for the Prevention of Torture 2007 ISBN 2-940337-16-0

7 Pendell A (2009) Dick Cheney’s ‘Torture Worked’ Evidence refuted in DOJ report <http://www.care2.com/causes/politics/blog/dick-cheney-s-torture-worked-evidence-refuted-in-doj-report/> accessed 11 03 11

What is medical complicity in torture?

Medical complicity in torture occurs when physicians willingly take part in, facilitate, or allow torture by failing to report to the relevant authorities evidence which suggests that people have been tortured. Examples of direct participation in torture include providing medical knowledge to interrogators in order to aid interrogation, disregarding confidentiality of medical information, force-feeding people who are on hunger strike, and falsifying medical records or death certificates.⁸

Medical complicity in torture often takes place in prison and detention settings. This is due to a situation known as ‘dual loyalty’, which causes clinicians to put the perceived interests of their employers or the state above their duties to their patients.⁹ This presents an ethical dilemma because a medical professional employed by a prison using torture might feel pressured to cooperate with, or may even identify with, the objectives of prison authorities. This is in direct conflict with the absolute duties of medical professionals to respect and protect the rights of those in their care.

The World Medical Association (WMA) and the prevention of torture

The WMA was officially formed in September 1947 by professionals from 27 National Medical Associations (hereafter NMAs), and presently consists of 98 NMAs. The original intention was to create a professional society to protect the rights and interests of medical professionals. However, one event significantly shaped another goal of the WMA, for it was around this time that the atrocities of World War 2 were exposed, including the participation of Nazi doctors in appalling and unethical experiments. This made it evident that clear, ethical standards for medical professionals were lacking. The WMA stepped up as the body to provide those ethical guidelines.¹⁰ Standards set by the WMA range from ethical considerations in medical research, through responsibility towards patients, to issues such as ethical medical treatment in prisons.

The WMA, because of its involvement in ethics, is inevitably involved in the prevention of medical complicity in torture. The WMA’s primary function in this regard is to establish ethical standards that

unambiguously reject medical complicity in torture and to act to ensure that medical professionals uphold these standards. This support is needed particularly by physicians working in state-run facilities, who can come under pressure to comply with state officials. The WMA has made its stance on this issue clear through various ethical guidelines. For example, the WMA’s Declaration of Helsinki¹¹ concerns medical research involving human beings, and the Declarations of Tokyo¹², Hamburg¹³ and their amendments provide guidelines specific to torture.

The WMA was a participating member in the creation of the Istanbul Protocol¹⁴, a UN document which provides internationally recognized guidelines that define torture, and criteria for recognising the medical evidence of torture that has (or may have) occurred. This document reiterates the ethical obligations that physicians have towards those in their care. It also highlights the moral duty of physicians to protect detainees against torture, not to participate in it themselves, to report suspicions that

8 World Medical Association (adopted 1975) WMA Declaration of Tokyo Op. cit

9 International Dual Loyalty Working Group (2002) Dual Loyalty & Human Rights in the Health Professional Practice: Proposed Guidelines & Institutional Mechanisms. Physicians for Human Rights and School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty 2002 ISBN 1-879707-39-X

10 Grodin, Annas and Glantz (1993) Medicine and Human Rights A Proposal for International Action. The Hastings Center Report Vol.23 No.4 Jul–Aug 1993 pp. 8-12

11 World Medical Association (adopted 1964) WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects. <http://www.wma.net/en/30publications/10policies/b3/> accessed 11 03 11

12 World Medical Association (adopted 1975) WMA Declaration of Op. cit

13 World Medical Association (adopted 1997) WMA 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 <http://www.wma.net/en/30publications/10policies/c19/index.html> accessed 11 03 11

14 Office of the UN High Commissioner for Human Rights (2004) Istanbul Protocol. Professional Training Series No.8/Rev.1 <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf> accessed 11 03 11

those in their care may have been tortured, and to support colleagues who speak out against human rights violations. It addresses directly the issue of ‘dual loyalty’.

Although it is possible for individual physicians to join the WMA, most gain membership through their NMAs, which are constituent members of the WMA. This relationship means that most physicians affiliate with the WMA in groups rather than as individuals, and that the WMA has powers over NMAs (suspension of membership for instance), but not usually over individual physicians. Declarations made solely by the WMA are not legally binding, and the WMA is not responsible for issuing medical licenses to medical professionals. This leaves the WMA powerless to discipline medical professionals who have disregarded ethical standards. Furthermore physicians may not belong to their NMA, even if that NMA is affiliated to the WMA; again this would

affect the WMA’s power to discipline a physician. Two of the NMAs covered in the case studies – Sri Lanka and Italy – are not currently members of the WMA.

The inability of the WMA to enforce the ethical principles it declares has been criticised in the past. This was apparent in 1993 when four nuns declared that Hans-Joachim Sewering, the German president-elect of the WMA, had been responsible for sending child patients from the Institute for the Handicapped where he worked to their deaths at the Eglfing-Haar Hospital during World War 2. Although Sewering denied knowledge of the fates of the children, he did step down as president of the WMA.¹⁵ The fact that someone who had committed an act so against the ethics promoted by the WMA could have risen to such a high position is an extreme but worrying example.

National Medical Associations (NMAs)

NMAs exist in many countries. They are made up of medical professionals from across the nation. The role and functions of NMAs differ from country to country. Some, like the British Medical Association, are registered trade unions, and lobby for improved pay and conditions of employment. NMAs may lobby their national government to change health related policy, raise specific patient issues of national concern and provide information about medical careers. In addition, like the WMA, NMAs have often issued ethical guidelines for physicians. Because NMAs are closer to the ground than the WMA, they might be expected to be more capable of assessing more specifically the concerns of their members.

Where an alleged or a definite breach of ethics is concerned, the reactions from NMAs depend on their specific role in censuring and punishing wrongdoing, their willingness to do so, and their mandates. NMAs vary significantly from nation to nation. In some countries they are organisations for medical professionals to join voluntarily in order to discuss medical issues and gain support from colleagues. In others the NMA is responsible both for providing this sort of forum, and for the licensing of medical professionals. The specific roles and responsibilities of an NMA thus significantly impact

on the relationship of medical professionals to that NMA and the way they interact with it.

NMAs have often been successful in combating medical complicity in torture although this has sometimes been after the event. In Chile hundreds of people were tortured under the Pinochet regime. When the regime ended, the Chilean Medical Association carried out an investigation and expelled six doctors who were found to be complicit in torture. In South Africa two doctors were punished eight years after failing to treat or report the injuries that killed the political prisoner Steve Biko in 1977.¹⁶ The latter followed a long and sustained international campaign, one result of which was the withdrawal of the Medical Association of South African (MASA) from the WMA in anticipation of its expulsion. When the WMA agreed in 1984 to re-admit MASA, the BMA protested by temporarily withdrawing from the WMA.

Though some NMAs take quite a rigorous stance regarding medical complicity in torture, others seem to have less ability, or enthusiasm, to do so. A recent example of this is the American Medical Association (hereafter AMA) in its dealing with medical complicity in torture at Guantánamo Bay. Though medical professionals were complicit in torture at

15 Grodin, Annas and Glantz (1993) Op. cit.

16 Miles S (2008) Doctor’s Complicity with Torture *BMJ* 2008;337:a1088

Guantánamo, the AMA stated that the Association does not have regulatory or licensing powers to censure these individuals. Rather, the AMA took this opportunity to reiterate its support for the Tokyo Declaration¹⁷ and to issue a new policy regarding the participation of physicians in interrogations.¹⁸

It is important to note that the responsibility of an NMA for medical licensing is an important factor in its potential for applying significant sanctions when responding to medical complicity in torture, and that the roles of different NMAs relating to legal, disciplinary and medical registration (licensing) powers vary. In the UK, for example, the General

Medical Council (GMC) is the statutory licensing body with professional and ethical disciplinary responsibility, while the BMA is a trade union and independent voluntary professional association which publishes influential ethical guidelines but works separately from the GMC.

In Israel most doctors are members of the Israel Medical Association (IMA), which sets ethical guidelines, holds enquiries into professional misconduct, and can expel members, although only the Ministry of Health can revoke licences to practise. The IMA states that prison doctors are ‘under-represented’ in IMA membership.

17 Nicholl D (2006) Guantanamo: A Call for Action: Good Men Need to do Something. *BMJ* 2006 April 8; 332: published April 6 2006

18 O’Reilly K (2006) AMA Adopts Policy on Interrogations. <http://www.ama-assn.org/amednews/2006/07/03/prse0703.htm> accessed 11.03.11

UN Resolution on Torture A/HRC/10/L.32 and the UN Human Rights Council

The prevention of torture has been at the forefront of the UN agenda for some years. The UN Convention Against Torture defines torture and forbids states to use it. Article 4 specifically prohibits acts of complicity in torture. In addition, this Convention led to the creation of a Committee against Torture, which is able to monitor and receive individual complaints. To date 147 states are party to this Convention.

In March 2009, to complement the Convention Against Torture, the Human Rights Council passed UN Resolution A/HRC/10/L.32 specifically to address medical complicity.¹⁹ This is an important development for several reasons.

- a) Once a state ratifies a Convention it becomes a legally binding document. This means that medical professionals who are willingly complicit in torture could be held legally responsible. It also means that states could be held legally responsible for pressuring physicians into being complicit in torture. The legal element also provides additional protection for physicians who speak out against torture.
- b) Secondly, this resolution applies to the state's responsibilities, which the WMA's Declarations do not. Though medical professionals may feel ethically obligated to abide by standards set out by the WMA, the WMA does not regulate states. This document provides a clear set of standards by which states must abide.
- c) Another important aspect of this UN Resolution is the possibility it provides for monitoring. It calls for states to establish independent preventative mechanisms. The Resolution also tasks the UN Special Rapporteur on Torture with:
 - responding to credible and reliable information about health professionals' participation in torture or ill treatment;
 - ascertaining that health professionals remain independent of the institutions in which they serve;
 - discussing cooperative efforts with the World Health Organization and other relevant UN bodies addressing the roles and responsibilities

- of health professionals in the documentation and prevention of torture and ill treatment;
- reporting to the UN Human Rights Council on the problem of health professionals' participation in torture.²⁰

Given that the UN Resolution on Torture wields a significant amount of power and the WMA has contact with medical professionals, it seems appropriate to consider how the UN Human Rights Council and the WMA might work together. The WMA could set up a complaints procedure whereby medical professionals (and others as appropriate) could voice concerns over actions by physicians which are believed to violate ethical guidelines. The WMA could then act as an advocate on behalf of these 'whistle blowing' medical professionals, while the UN Special Rapporteur would in turn investigate these cases as his mandate allows him to.

However, cooperation between the WMA and UN Human Rights Council could also have negative effects. As stated above, the role of the WMA is to advocate for physicians' rights, and the additional responsibility of censuring members may complicate this role. All medical professionals would be subject to monitoring and potentially to censure by the UN, and WMA cooperation could undermine its relationship with some WMA members; however this would be even more likely if the WMA – or indeed any NMA – held the responsibility for both advocacy and censure within their organisation.

In March 2010 the International Rehabilitation Council for Torture Victims (IRCT) and the WMA jointly hosted an event at the 13th session of the UN Human Rights Council on 'Exploring Sustainable Systems to Document Torture – The Role of Health Professionals.'²¹ Those present emphasised the need for cooperation between different professionals, and the importance of training for both forensic and non-forensic physicians in their different roles, in relation to torture. Recommendations to countries included ensuring the confidentiality of forensic examinations, introducing systemic examination procedures, and independent and systemic methods of reporting torture.

19 Polatin, Modvyg & Rytter (2010) Helping to stop doctors becoming complicit in torture. *BMJ* 2010; 340:c973 (published 25 February 2010)

20 Ibid.

21 International Rehabilitation Council for Torture Victims (2010) UPDATED: At Human Rights Council the IRCT and WMA call for sustainable systems to document torture Press release IRCT 08 03 2010 <http://www.irct.org/news-and-media/irct-news/show-news.aspx?PID=13767&Action=1&NewsId=2466> accessed 11 03 11

National Case Studies

1. The United States

The present situation

Medical complicity in torture in Abu Ghraib Prison in Baghdad through silence has been quite extensive. In the US reports from the International Committee of the Red Cross, Human Rights Watch and US military personnel showed that health professionals falsified death certificates, failed to accurately report illnesses and injuries, and helped design, approve and monitor interrogations.²² Medical complicity in torture has also taken place in the Guantánamo Bay facility, the US base in Cuba. What originally began as a group of psychologists teaching military members how to cope with torture if captured became behavioural scientific consultation teams or BSCTs.²³ These teams were responsible for developing interrogation techniques at Guantánamo, including providing detailed information on individual detainees and the stressors they might respond to, as well as determining whether detainees were able to undergo further interrogation. In 2011 a review of the medical records and case files of nine of the detainees at Guantánamo showed that ‘medical doctors and mental health professionals assigned to the US Department of Defense neglected and/or concealed medical evidence of intentional harm.’²⁴ All had been detained in Guantánamo since 2002 and had been there for an average of 7 years. In addition, force-feeding has frequently been applied to hunger strikers at Guantánamo, despite a declaration by the World Medical Association that this practice is not ethical.²⁵

Medical complicity has also been associated with extraordinary rendition. A detainee who had been flown to Stare Kiejkuty, an intelligence base in Poland, is reported as saying that his torture was stopped by “the intervention of the doctor.”²⁶

Uncovering torture and the response

Torture occurring in US detention facilities came to light when Joe Darby, a military policeman visiting Abu Ghraib, turned in photographs he had come across showing the abuse of prisoners. However, this whistle blowing action came with consequences: after Donald Rumsfeld breached his anonymity Darby was labelled a traitor by many people. His home was vandalized and his family was forced to live under armed protection for six months.²⁷ Darby was not the only one who felt that the torture needed to be exposed; several soldiers have since come forward to say they should have reported this. However, when asked why they did not do so, soldiers spoke of the risks of reporting, as senior officials often knew what was going on and soldiers felt their jobs would be at risk.²⁸

After records became public the American Psychological Association (APA) Report of the Task Force on Psychological Ethics and National Security (PENS report)²⁹ reaffirmed its stance against the psychologists’ participation in interrogations. However, this statement was later amended to denounce only participation in coercive interrogation. This was followed by an open letter

22 Miles SH. Abu Ghraib: its legacy for military medicine. *Lancet* 2004; 364: 725–29

23 Fink S (2009) Tortured Profession: Psychologists Warned of Abusive Interrogations, Then Helped Craft Them. *ProPublica* May 5 2009. <http://www.propublica.org/article/tortured-profession-psychologists-warned-of-abusive-interrogations-505> accessed 11 03 11

24 Iacopino V, Xenakis SN (2011) Neglect of Medical Evidence of Torture in Guantánamo Bay: A Case Series. *PLoS Med* 8(4): e1001027. doi:10.1371/journal.pmed.1001027

25 World Medical Association (adopted 1991) Declaration of Malta on Hunger Strikers WMA <http://www.wma.net/en/30publications/10policies/h31/index.html> accessed 11 03 11

26 Swann S (2010) What happened in Europe’s secret CIA prisons? *BBC World News* <http://www.bbc.co.uk/news/world-11469369> accessed 07 06 11

27 Bryan D (2007) Abu Ghraib whistleblower’s ordeal. *BBC Radio 4’s The Choice* 5 August 2007 <http://news.bbc.co.uk/1/hi/6930197.stm> accessed 11 03 11

28 Zernike K (2004) The Reach of War: The Witnesses; Only a Few Spoke Up on Abuse as Many Soldiers Stayed Silent. *The New York Times* May 27 2004 <http://www.nytimes.com/2004/05/22/international/middleeast/22WITN.html> accessed 11 03 11

29 Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security (June 2005) <http://www.apa.org/pubs/info/reports/pens.pdf> accessed 11 03 11

from the American Medical Association (AMA) advocating that medical ethics and the Geneva Conventions be respected for detainees.³⁰ To date no US medical professional has been charged with any offence related to medical complicity in torture.³¹

However, there has also been positive action by medical professionals to end medical complicity in torture. Prominent physician Atul Gawande has recently spoken out about the damaging effects of solitary confinement – a form of torture under the Istanbul Protocol – from a medical perspective.³² Meanwhile medical professionals in Maine are supporting legislation (Bill LD 1611) to end the practice there, citing their duty to speak out against practices that harm prisoners.³³ The role of military psychiatrists in the detention of the US soldier Bradley Manning has also been questioned: while they have consistently said he does not need to be kept in solitary confinement he still is and they continue to monitor his condition, effectively trapped in a situation of dual loyalty.³⁴ The willingness and ability of medical professionals to engage in an open and meaningful dialogue about issues of torture is crucial to ending such practices.

The American Medical Association (AMA) and related bodies

Membership of the AMA is voluntary. State Medical Boards, which together make up the Federation of State Medical Boards, are responsible for registration and the licensing of physicians.

Ethical guidance for physicians is provided in the Principles of Medical Ethics and Opinions of the Council on Ethical and Judicial Affairs (CEJA).³⁵ CEJA evaluates the fitness of physicians to be members of the AMA, and has the authority to

request the President of the AMA to appoint an investigating jury to which CEJA can refer cases of possible unethical conduct that cannot be dealt with at state level by the Medical Boards.

The AMA was not a member of the WMA when the Tokyo Declaration was adopted in 1975; however the House of Delegates endorsed the declaration at their 1978 Interim Meeting, and this endorsement has been reaffirmed several times, most recently in 2005.³⁶

An Ad Hoc Physician Grassroots Network for Human Rights was established in 2009 by the Institute for Ethics and the International Medicine Group, in order to address physician persecution worldwide. It will place particular emphasis on physicians who are reported as persecuted and who have links with the US; those without such connections they may refer to the WMA.³⁷

The future and recommendations

We recommend that:

- the APA and AMA produce practical recommendations to follow up on their reports denouncing participation in coercive interrogation. Without these, health professionals will continue to be plagued by ‘dual loyalty’ – to detainee patients and to their military superiors.
- the AMA should take action to resolve confusion between the US Government and health professional bodies in relation to force-feeding. The Obama administration called for a report, later called the ‘Walsh Report,’ to investigate conditions at Guantánamo. It specifically – and inaccurately – reports that force-feeding of inmates is permitted by the Geneva Conventions.³⁸ However, the WMA condemns force feeding as unethical.

30 Behnke S (2006) Ethics and Interrogations: Comparing and contrasting the American Psychological, American Medical, and American Psychiatric Associations positions. July/August 2006 <http://research.apa.org/pubs/info/reports/pens-article.pdf> accessed 11 03 11

31 Nicholl, Jenkins, Miles, Hopkins, Siddiqui, Boulton and on behalf of 260 other signatories (2007) Biko to Guantánamo: 30 years of medical involvement in torture, *Lancet* Vol.370 Issue 9590 p 823 September 8 2007 <http://www.lancet.com/journals/lancet/article/PIIS0140-6736%2807%2961402-0/fulltext> accessed 11 03 11

32 Gawande A (2010) Interview. Democracy Now http://www.democracynow.org/2010/1/5/dr_atul_gawande_on_real_health accessed 11 03 11

33 Tapley L (2010) Are Doctors Complicit in Prison Torture? The Maine medical community looks at solitary confinement *The Portland Phoenix* April 21 2010 <http://portland.thephoenix.com/news/101033-are-doctors-complicit-in-prison-torture/> accessed 11 03 11

34 Pilkington (2011) Bradley Manning’s military doctors accused over treatment <http://www.guardian.co.uk/world/2011/mar/15/bradley-manning-military-doctors-treatment> accessed 07 06 11

35 American Medical Association Code of Medical Ethics <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml> accessed 11 03 11

36 American Medical Association <http://www.ama-assn.org/ama1/pub/upload/mm/38/a-10-bot-reports> accessed 26 02 11

37 *ibid*

38 US Department of Defense (2009) DoD News Briefing With Adam Walsh From the Pentagon. February 23 2009 <http://www.defense.gov/transcripts/transcript.aspx?transcriptid=4359> accessed 11 03 11

- the APA and AMA should ensure that all actions of medical professionals are for the benefit of patients. We support the call by Physicians for Human Rights that the Obama administration investigate the use of enhanced interrogation techniques and the use of detainees in unethical experiments. They allege that these techniques were applied to detainees who are also subjected to medical monitoring in order to gain a better understanding about the methods. This resulted in a change in the way some techniques were applied as well as reclassification of some from illegal to safe, legal and effective.³⁹ Without consent from detainees this is a clear breach of the Nuremberg Code.⁴⁰
- the AMA should reaffirm its stance on the ethics of force-feeding and advocate for its discontinuation as an act of cruel and inhumane treatment and a violation of Article 3 of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.⁴¹
- the AMA should support the recommendation by Physicians for Human Rights to amend the War Crimes Act in order to criminalise unethical experimentation on people, and to ensure consistency with the Geneva Conventions.⁴²

39 Hopkins Tanne J (2010) Bush administration should be investigated for torture of prisoners, says human rights group. *BMJ* 2010;340:c3182

40 The Nuremberg Code (1947) Permissible Medical Experiments <http://www.cirp.org/library/ethics/nuremberg/> accessed 15 02 11

41 Office of the United Nations High Commissioner for Human Rights (adopted 2002) Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment <http://www2.ohchr.org/english/law/cat-one.htm> accessed 11 03 11

42 Physicians for Human Rights (2010) Experiments in Torture: Evidence of Human Subject Research and Experimentation in the “Enhanced” Interrogation Program. A White Paper by Physicians for Human Rights June 2010

2. Sri Lanka

The present situation

For the last 25 years, Sri Lanka has been caught in the devastating grip of a violent conflict between the state government and the separatist Liberation Tamil Tigers of Elam (LTTE). Throughout this conflict, both sides have been found by the United Nations to have committed serious violations of international humanitarian law.^{43 44}

During the final months of the conflict that came to an end in May 2009, the UN and other agencies documented a spiralling humanitarian disaster, with the involvement of state officials and government security forces in assassinations, abductions, disappearances, torture, illegal arrests and detentions, and the indiscriminate shelling of densely populated areas including hospitals. Some of these events were captured on film including by the soldiers themselves.⁴⁵

The LTTE for its part continued to forcibly recruit civilians, including children, used civilians as human shields and at times physically prevented and shot at Tamil civilians trying to flee the fighting in areas under LTTE control. Both parties are accused of preventing vital humanitarian assistance from reaching the civilian population. The conflict is reported to have claimed between 80,000 and 100,000 lives and left hundreds of thousands physically and psychologically injured and traumatised. The 2011 Report of the [UN] Secretary-General's Panel of Experts on Accountability in Sri Lanka documents the extensive use of torture which it is difficult to imagine doctors, in particular those associated with the armed forces, police and prison service, did not know about.⁴⁶

Prior to these recent events there has been a history of concern over torture in Sri Lanka and medical complicity in it. At the same time there have been attempts by medical professionals – often at their personal risk – to reveal the extent of the problem.

Uncovering torture and the response

In 2007, following a visit to Sri Lanka, Manfred Nowak, the UN Special Rapporteur on Torture, reported that torture was 'widely practiced' and that 'this practice is prone to become routine in the context of counter-terrorism operations, in particular by the TID' [Terrorist Investigation Department].⁴⁷ Torture is specifically prohibited in the 1978 constitution of the Democratic Socialist Republic of Sri Lanka. Article 11 of the constitution states that 'No person shall be subject to torture, or to cruel, inhuman or degrading treatment or punishment.'

One piece of work by Perera examined the medical records of 100 victims of torture between 1998 and 2001 held by the Judicial Medical Officer's Office in Colombo the capital of Sri Lanka.⁴⁸ Sixty-eight different methods of torture were identified which included assault with blunt and sharp weapons, burns with lighted cigarettes, 'wet submarino' (immersing the victim's head in a container full of water until the person nearly drowned), 'dry submarino' (putting the victim's head inside a plastic bag until the person nearly suffocated), kicking, 'hanging' and electrocution.

The exact incidence of torture during the Sri Lankan conflict remains unknown, but consistent patterns reveal that these incidents are far from isolated. In 2007, the Medical Foundation for the Care of Victims of Torture in the UK reviewed 130 cases from Sri Lanka, referred to the Foundation in the previous year. Of these, 55 clients reported being beaten with implements ranging from truncheons to electric cables, 30 reported being burned with cigarettes, and 20 reported being partially suffocated by a plastic bag soaked in petrol being placed over the head. Other common torture methods included suspension by the ankles and 'falanga' (beating of the soles of the feet). Twenty-four women and 22 men who sought help from the Foundation reported

43 Human Rights Watch (2009) World Report: Sri Lanka. New York <http://www.hrw.org/en/node/87402> accessed 11 03 11

44 Vije M Ratneswaren S (2009) Enduring ward and health inequality in Sri Lanka, Tamil Information Centre, Kingston-upon-Thames UK <http://www.tamilinfo.org/healthreport.pdf> accessed 11 03 11

45 Channel 4 (2011) Sri Lanka's Killing Fields shown on 14 06 11 Channel 4 Dispatches

46 United Nations (2011) Report of the Secretary-General's Panel of Experts on Accountability in Sri Lanka 31 March 2011 http://www.un.org/News/dh/infocus/Sri_Lanka/POE_Report_Full.pdf accessed 15 06 11

47 OHCHR (2007) Special Rapporteur on Torture concludes visit to Sri Lanka <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=7898&LangID=E> accessed 11 03 11

48 Perera P (2006) Scars of Torture: A Sri Lankan study Faculty of Medicine, Dept of Forensic Medicine, University of Kelaniya Sri Lanka. *Journal of Clinical Forensic Medicine* 2006 August 17 16919991

having being raped.⁴⁹ Similarly, in 2004, a document produced as part of the Istanbul Protocol Implementation Project noted that horrendous physical and psychological torture appeared widespread in Sri Lanka.⁵⁰

The Asian Human Rights Commission has documented at least two cases where doctors have been alleged to be complicit in covering up torture. In one case, a victim reported being beaten, kicked and hung by his wrists in a form of torture known as a 'Palestinian Hanging' that left him with nerve damage, following which petrol was poured into his anus.⁵¹ When the authorities finally took him to a government hospital for a medico-legal examination prior to being charged in court, the attending doctor allegedly signed the medico-legal form without examining him. When another prison officer took him for a further medical examination to a different hospital a few days later, the doctor he saw there accused him of lying about what had happened to him.

In a similar case documented by the Asian Human Rights Commission, another alleged victim was arrested on suspicion of theft and hung naked by police with his handcuffed hands between his legs and a large pole was used to lift him off the ground.⁵² He was allegedly beaten by police and he developed painful swollen legs. When his condition became so bad that he could hardly move, he was taken to a government hospital where the attending physician refused to treat him, telling him his case should be managed by a larger hospital. When he was taken to a larger hospital he claimed that a doctor there again refused to examine him.

The document produced as part of the Istanbul Protocol Implementation Project was entitled 'Medical Aspects of Torture as seen in Sri Lanka'.⁵³ It was aimed at increasing awareness of the incidence of

torture in Sri Lanka and as a practical training reference for health care professionals and lawyers involved in the care of torture victims. The report found that doctors charged with assessing and managing victims of torture often lacked adequate training, resources and facilities. Police were also often present at consultations – representing a breach of medical confidentiality and a source of potential intimidation.⁵⁴

In 2007 a Judicial Medical Officer was removed from the register of the Medical Council for three years for failing to adequately examine a torture victim. The Council's Professional Conduct Committee said that, in not striking off the doctor completely, they took into account his young age and the fact that 'this is the first occasion a complaint of this nature has come before this committee'.⁵⁵

However there are many other cases in which no other action was taken, such as the death of Garlin Kankanamge Sanjeeva, who the police stated committed suicide inside the police station. The medical report was contested but no action was taken against the medical officer involved.⁵⁶

In 2005 the report of a visit by the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions stated that:

'The lack of investigative capacity is due to a lack of police training and resources, ineffective forensics, and an unwillingness to ensure the security of witnesses. The Judicial Medical Officers (JMOs) who carry out most autopsies typically lack the requisite vehicles, equipment and specialized training. The range of obstacles to a prompt and effective examination means that too much evidence simply bleeds out onto the floor. Investigations are also impeded by the lack of effective witness protection. This makes witnesses especially reluctant to provide

49 Medical Foundation for the Care of Victims of Torture (2007) Torture once again rampant in the Sri Lanka conflict. Medical Foundation for the Care of Victims of Torture 2007 http://www.torturecare.org.uk/files/Torture%20once%20again%20rampant%20in%20the%20Sri%20Lanka%20conflict_0.pdf accessed 02 11 10

50 Istanbul Protocol Implementation Project 2003–2005 (2004) Medical Aspects of Torture as seen in Sri Lanka <http://www.irct.org/Files/Filer/publications/ipip/National-adaptation-Sri-Lanka-medical-material.pdf> accessed 08 02 11

51 Asian Human Rights Commission (2009) Sri Lanka: Police, doctors and magistrates are complicit in a man's torture. AHRC Urgent Appeals Programme December 2 2009 <http://www.ahrchk.net/ua/mainfile.php/2009/3329/> accessed 11 03 11

52 Asian Human Rights Commission (2010) Sri Lanka: Baduraliya police illegally arrest and torture a man. AHRC Urgent Appeals Programme July 28 2010 <http://www.ahrchk.net/ua/mainfile.php/2010/3513/> accessed 11 03 11

53 Istanbul Protocol Implementation Project 2003–2005 (2004) Medical Aspects of Torture as seen in Sri Lanka <http://www.irct.org/Files/Filer/publications/ipip/National-adaptation-Sri-Lanka-medical-material.pdf> accessed 08 02 11

54 *ibid*

55 The Case of Dr WR Piyasoma (2007) in the Professional Conduct Committee of the Sri Lanka Medical Council <http://www.janasansadaya.org/page.php?id=119&lang=en> accessed 08 02 2100

56 Pinto-Jayawardena (2009) The Rule of Law in Decline; study on prevalence, determinants and causes of torture and other forms of cruel, inhuman or degrading treatment of punishment (CIDTP) in Sri Lanka Rehabilitation and Research Centre for Torture Victims pp190 ISBN: 978-87-9087827-6 supported by the Rehabilitation and Research Centre for Torture Victims (RCT)

evidence on crimes committed by police officers, and led several interlocutors to joke that it would be better to be a victim than a witness.⁵⁷

How common medical indifference or even complicity is in the perpetration of torture in Sri Lanka remains unclear. However, doctors may understandably be intimidated by government officials and prison officers, as these authorities are often present during medical examinations, and doctors were targeted when they came forward as key witnesses in the final stages of the conflict. In 2009, five doctors were arrested and held for a number of months after they reported on government shelling and civilian casualties when working in areas under LLTE control.⁵⁸ Whilst in detention these doctors retracted their previous statements, and were threatened with the potential charge of treason.

The Sri Lanka Medical Association (SLMA) & related bodies

The Sri Lanka Medical Council is the regulatory body for the medical profession, while the SLMA ‘aims to provide a forum for its members to further their professional and academic development’.⁵⁹ Among other things it organises postgraduate meetings and publishes the Sri Lanka Medical Journal. The SLMA is not presently a member of the WMA. The Government Medical Officers Association acts as a trade union for the majority of doctors (of all grades) working in the government sector, and has 7000 members and 65 branches.⁶⁰

The website of the SLMA’s Declaration on Health states that everyone ‘when ill, [is] to be treated always with care and compassion, by the attending health professionals in particular’ and should be ‘afforded confidentiality and privacy during consultation, examination, investigation and treatment’.⁶¹ In the 2010 SLMA Country Report the Ethics Committee is mentioned as having ‘conducted workshops on Clinical Ethics at scientific meetings of Regional Associations and Professional Colleges’.⁶² The Forum for Ethics Review Committees in Sri Lanka, which

is convened by the SLMA, focuses on ethics related to research, rather than on ethics of care.⁶³

It is clear that doctors in Sri Lanka come under considerable pressure not to report torture, that they are often in the company of police officers when they examine victims, and sometimes have inadequate facilities. However there appears to be very little support from their professional bodies in these circumstances, or recognition of the need for adequate training and conditions.

The future and recommendations

Action on both medical complicity in torture, and the support of medical whistleblowers in Sri Lanka, is challenging partly because of the level of abuse of human rights in society in general.⁶⁴ However doctors as a profession are held in high respect in Sri Lanka, and action by them could have a positive influence on society as a whole.

We recommend that:

- the SLMA becomes a member of the WMA; this would both support WMA legitimacy, and strengthen international and local policies to fight torture.
- the Government of Sri Lanka, the SLMA and the Sri Lanka Medical Council work together to ensure the independence of doctors examining detainees and prisoners.
- the above named bodies should work with police, the armed forces, magistrates and other relevant groups, to ensure they are aware of the rights of detainees and prisoners, including their right to an independent medical examination and the use of evidence from this in legal proceedings.
- the SLMA, as part of its work on professional and academic development, should ensure that training in forensic medical examination and human rights protection, are included in undergraduate and postgraduate meetings, and that the number of forensic medical specialists is increased nationally.
- the SLMA should provide more support for medical professionals speaking out against and taking action to try to prevent torture.

57 UN Economic & Social Council, Commission on Human Rights 62nd Session. Civil and Political Rights, including the question of disappearances and summary executions. Report of the Special Rapporteur, Philip Alston, Addendum. Mission to Sri Lanka (Nov 28–Dec 6 2005) E/CN.4/2006/53/Add.5 27 March 2006

58 Human Rights Watch (2009) World Report: Sri Lanka. New York <http://www.hrw.org/en/node/87402>

59 <http://www.slma.lk/index.php> accessed 08 02 11

60 Government Medical Officers’ Association <http://www.gmoa.lk/aboutus.php?PHPSESSID=68e633a7e4cee227bd136fabc6a9ff> accessed 08 02 2011

61 Sri Lanka Medical Association Declaration on Health (revised 2005) <http://www.slma.lk/static/doh.php> accessed 16 02 11

62 Karunathilake I (2010) Country Report Sri Lanka Medical Association JMAJ, November /December 2010—Vol. 53, No. 6 http://med.or.jp/english/journal/pdf/2010_06/377_382.pdf accessed 16 02 11

63 Forum for Ethical Reviews Committees in Sri Lanka <http://www.fercsl.net/> accessed February 16th 2011

64 Vije & Ratneswaren (2009) Enduring War & Health Inequality in Sri Lanka. Tamil Information Centre UK ISBN 1 85201 021 5

3. United Kingdom

The present situation

Historically there was medical complicity in torture in some British colonies. For example Dr. J.C. Carothers, a British colonial psychiatrist, was implicated in designing interrogation of Mau Mau prisoners in Kenya in the early 1950s.⁶⁵ The Kenyan Human Rights Commission has said that 90,000 Kenyans were executed or tortured between 1952 & 1961;⁶⁶ given the extent of the use of torture it would be surprising if this did not involve further medical complicity. Between 1970 and 1971 there was also medical complicity in torture during the conflict in Northern Ireland when mentally disorienting interrogation techniques were used on interned prisoners. Following a complaint by the Irish government, the European Commission for Human Rights found Britain guilty of torture; however the European Court of Human Rights (a higher authority) ruled that the British government's actions were 'inhuman and degrading but did not constitute torture.'⁶⁷ This attempt to discriminate between 'torture' and 'inhumane and degrading treatment' is artificial: there is agreement that Article 3 of the European Convention on Human Rights, in which they both occur, 'is absolute in nature, meaning that there are no circumstances in which it can be derogated from, nor can there be any justification for failure to observe it'.⁶⁸

As recently as 1974 medical complicity in force-feeding was openly taking place in the UK, against the will of prisoners in a mental state to make an informed decision. Young Irish prisoners in Brixton prison were forcibly fed during a hunger strike which took place from November 1973 to mid-1974. One of the doctors supervising the feeding was alleged to

have said that he did not want to participate but was doing so on the orders of the Home Office.⁶⁹ Two women prisoners issued proceedings against the Home Office which then asserted that 'The doctor's obligation is to the ethics of his profession and to his duty at common law: he is not required as a matter of prison practice to feed a prisoner artificially against the prisoner's will'.⁷⁰ The clearly expressed wishes of the hunger strikers were respected in Northern Ireland in 1981 in accordance with article 5 of the Declaration of Tokyo. That year there were 12 fatalities as a result of hunger strikes in Europe – of these 10 occurred in Belfast.⁷¹ Since that time, UK policy has been to forbid involuntary feeding of patients assessed not to lack capacity. This is clearly summarised in Guidelines⁷² produced by the UK Department of Health, after some delay⁷³. These Guidelines may be the most precise statement currently available anywhere about appropriate medical care for hunger strikers.

There has been considerable concern in recent years about the treatment of immigration detainees, both in relation to whether evidence of torture prior to their arrival in the UK is recognised, reported and acted on, and in relation to their treatment after arrival in the UK – particularly in privately run detention and removal centres, and during the process of removal.⁷⁴ There has also been increasing concern about the treatment of prisoners in Iraq and Afghanistan by British troops, and about the role of military doctors – particularly as to whether they raised concerns following the examination of patients showing clear signs of abuse.⁷⁵

In 2007 the Medical Justice Network noted that 'the medical services in detention centres rarely

65 The Daily Nation Special Report Part 3 (2004) Horrors of the Hola detention camp 22 04 2004 OGIEK Home

66 Channel 4 News (2011) British Government long aware of Mass Kenyan torture <http://www.channel4.com/news/britain-accused-of-mass-torture-on-kenyans-in-1950s> accessed 07 06 11

67 50 years of activity: European Court of Human Rights – Some Facts and Figures http://www.echr.coe.int/NR/rdonlyres/ACD46A0F-615A-48B9-89D6-8480AFCC29FD/0/FactsAndFigures_EN.pdf accessed 11/08/2010 .

68 Your Rights: the Liberty Guide to Human Rights <http://www.yourrights.org.uk/yourrights/rights-of-immigrants/european-convention-on-human-rights/article-3-prohibition-of-torture-or-inhumane-or-degrading-treatment.shtml> accessed Sept 15 2010

69 Moore M Force-feeding of prisoners (letter) *Lancet* 1974 3:52

70 Roy Jenkins, Home Secretary 17 July 1974 Hansard 877 col. 451, 1974

71 Duhamel O (1984) Sketch of a typology of hunger strikes. *La Greve de la Faim*. Paris, *Economica* p23

72 Offender Health, Department of Health (2010) Guidelines for the clinical management of people refusing food in immigration removal centres and prisons. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104769 accessed 11 03 11

73 Editorial. Clinical care of hunger strikers. *Lancet* 372; 777: 2008.

<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2808%2961313-6/fulltext> accessed 06 03 11

74 Birnberg Peirce & Partners (2008) Outsourcing Abuse: the use and misuse of state-sanctioned force during the detention and removal of asylum seekers. Medical Justice and the National Coalition of Anti-Deportation Campaigns

75 Cobain I (2010) Abuse claims lift cloak of secrecy over Britain's Iraq interrogation base *The Guardian* 5 November 2010 <http://www.guardian.co.uk/uk/2010/nov/05/military-iraq> accessed 03 12 10

have the capacity or expertise to deal with the wide range of serious mental and physical conditions presented by detainees'. Twenty of 56 detainees that they examined in 2006-7 gave a history prior to their arrival in the UK 'consistent with', 'highly consistent with' or 'typical of' torture (Istanbul Protocol definitions)⁷⁶. The report of a visit by the government's Inspector of Prisons to Harmondsworth Immigration Removal Centre in 2006 noted that no response had been received to 57 reports of evidence of torture that had been sent to the Centre Manager by examining doctors, and that the staff had received no specific training in the management of those who had been tortured, despite this being a recommendation of the two previous visits by the Inspector.⁷⁷ Training had still not been carried out by 2010.⁷⁸

People who are refugees because they were tortured in their countries of origin, are usually registered with National Health Service General Practitioners, to whom they may present with complex medical problems. They may need particular care and a specialist referral. Sometimes, particularly in secondary care, clinicians treating them are subjected to management pressure to abandon their patients because of cost and time issues.

The documentation of evidence of torture can be of crucial importance to claims for international protection. Clinicians working for organisations such as the Medical Foundation for the Care of Victims of Torture, the Medical Justice Network (MJN) and the Helen Bamber Foundation also provide medico-legal reports for use in support of humane and lawful determinations of the cases of asylum seekers in the community.

Approximately 20,000 people are subjected to administrative detention each year for immigration purposes, including 'failed' asylum seekers, foreign nationals who have finished a prison sentence, and visitors who have overstayed their visas. This type of detention is not for a crime, however it is indefinite, and to date the longest time someone has been

detained is eight years. A significant number are survivors of torture, and their experience of detention is re-traumatising, as it recapitulates previous experiences. It is UK government policy that torture survivors should be detained 'only under very exceptional circumstances'⁷⁹ however there are frequent failures of this 'rule 35' process. Medical treatment in detention has also frequently been inadequate.⁸⁰

The detention centre rules also require that detainees shall be allowed access to independent doctors. Such examinations, usually via the MJN, have contributed to release, recognition of legitimate (and previously ignored) asylum claims, and/or compensation for wrongful detention in numerous cases in the past five years.

There are cases of asylum seekers sustaining injuries as a result of 'control and restraint' during transportation from or around the UK, injuries which have been inadequately documented and reported. In October 2010 Jimmy Mubenga died, apparently of positional asphyxiation, while being deported to Angola on a British Airways passenger flight in the custody of three G4S security personnel.⁸¹ There have, however, been a number of successful claims for compensation, often after documentation of injuries by doctors from MJN.

In the (at the time of writing) ongoing investigation into allegations of torture by the UK armed forces in detention facilities in Iraq, the role of doctors belonging to the armed forces remains unclear. A Lance Corporal described as a 'junior army medic' admitted kicking, punching, and observing the hooding of a 14-year-old Iraqi boy as part of a Royal Military Police investigation in 2008. A nurse who allegedly sexually abused and over-medicated an Iraqi detainee asked him not to tell the duty doctor⁸².

There is strong evidence for British government complicity in torture of prisoners detained overseas, including of one medical student,⁸³ and this has

76 Medical Justice (2007) Beyond Comprehension and Decency: an introduction to the work of Medical Justice p9 Medical Justice July 2007 <http://www.medicaljustice.org.uk/images/stories/reports/medical%20justice%20report%20-%20beyond%20comprehension%20%26%20decency.pdf> accessed 11 03 11

77 HM Chief Inspector of Prisons (2006) report on a full unannounced inspection of Harmondsworth Immigration Removal Centre 17-26 July 2006 <http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/harmondsworth1-rps.pdf> accessed 08 03 11

78 HM Chief Inspector of Prisons (2006) report on an unannounced inspection of Harmondsworth Immigration Removal Centre 11-15 January 2010 http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/Harmondsworth_2010_rps.pdf accessed 08 03 11

79 The Detention Centre Rules 2001 No 238 <http://www.legislation.gov.uk/uksi/2001/238/contents/made> accessed 08 02 2011

80 Arnold et al (2006) Unmet medical needs in detention <http://www.bmj.com/content/332/7536/251/reply> accessed 08 02 2011

81 Jimmy Mubenga family call for inquiry into deportation system (2010) Monday November 1st 2010 <http://www.guardian.co.uk/uk/2010/nov/01/jimmy-mubenga-family-deportation-inquiry> accessed 16 02 11

82 Verkaik R (2009) British soldiers sexually abused us, claim Iraqis The Independent Nov 15th 2009 <http://www.independent.co.uk/news/uk/home-news/british-soldiers-sexually-abused-us-claim-iraqis-1820973.html> accessed 11 03 11

83 Human Rights Watch (2009) Cruel Britannia: British Complicity in the Torture and Ill-treatment of Terror Suspects in Pakistan. HRW 1-56432-571-7

sometimes been following rendition from other countries.⁸⁴ There have also been allegations of British medical personnel in Iraq being aware of torture. At the time of writing, a public inquiry is being sought by 222 former inmates of facilities run by the UK Joint Services Intelligence Organisation. Most of their submissions say that on arrival at a UK military base they would be examined by a military doctor, but that the doctor would take no interest in their injuries.⁸⁵ It has been openly admitted that the 'standard of [their (our international allies)] interrogation methods are not as scrupulous as our own'⁸⁶ and one detainee returning to the UK having been tortured was not fit to go to jail.⁸⁷

Uncovering torture and the response

Doctors have acted, with some positive results, both to draw attention to abuse and to improve the situation for individual detainees in immigration detention centres and in prisons.

The BMA's Torture Report of 1986 stressed that it was possible and necessary for NMAs to take a stand on torture and that they should ratify the Declaration of Tokyo. In 1992 this was followed up with 'Medicine Betrayed'⁸⁸, which also covered controversial issues in the UK: the detention of asylum seekers, the use of the Prevention of Terrorism Act and the ill treatment of detainees in Northern Ireland. In April 2009 the BMA stated that they were 'seriously concerned about recent reports citing possible medical complicity in torture and ill-treatment of inmates at the United States detention camp in Guantánamo Bay'. In 2009 the BMA issued guidance on 'The medical role in restraint and control: custodial settings',⁸⁹ and published the 3rd

edition of its advice on treatment of detainees in police stations,⁹⁰ which specifically recognises the potential conflict between the duties of the doctor and those of the prison authorities.

As described above, there have been cases in the UK where torture committed elsewhere has not been reported. Some likely reasons for this include inexperience, lack of training and peer pressure.

In the case of the abuses that led to the death of Baha Mousa, a 26-year-old Iraqi hotel receptionist who was beaten to death whilst in British army custody in Basra in September 2003, Dr Vivienne Nathanson, Director of Professional Activities at the BMA, said that there was apparently 'a remarkable level of ignorance about the rules applicable to the health care of detainees'.⁹¹ In his evidence to the Inquiry the Surgeon General at the time of Baha Mousa's death drew attention to the lack of training in the treatment of detainees available for medical officers in the early 2000s, compared to that provided in the 1970s in the context of Northern Ireland.⁹²

The British Medical Association (BMA) & the General Medical Council (GMC)

The BMA is an independent trade union and membership is voluntary. Its Medical Ethics Committee and Medical Ethics Department promote ethical practice, including by producing ethical guidelines and advising individual doctors. In 2011 the BMA is proposing a further revision to the Tokyo Declaration, specifically to strengthen support for 'the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.'⁹³

84 Qureshi A (2011) Fabricating Terrorism III Cageprisoners <http://www.cageprisoners.com/our-work/reports/item/1063-fabricating-terrorism-iii-british-complicity-in-rendition-and-torture> accessed 02 03 11

85 Cobain 1 (2010) Abuse claims lift cloak of secrecy over Britain's Iraq interrogation base. The Guardian Friday 5 November 2010 <http://www.guardian.co.uk/uk/2010/nov/05/military-iraq?intemp=239> accessed 11 03 11

86 McGrory D (2005) American 'Ghost Prisoners' May Yield Vital Clues The Times August 2 2005 <http://www.thetimes.co.uk/tto/public/sitesearch.do?querystring=American+%E2%80%98Ghost+Prisoners%E2%80%99+May+Yield+Vital+Clues+&p=tto&pf=all&bl=on> accessed 11 03 11

87 Cageprisoners (2009) Fabricating Terrorism II British complicity in renditions and torture Cageprisoners April 2009 <https://www.cageprisoners.com/our-work/reports/item/106-fabricating-terrorism-ii-british-complicity-in-renditions-and-torture> accessed 11 03 11

88 BMA (1992) Medicine Betrayed: the Participation of Doctors in Human Rights Abuses. Report of a Working Party. Zed Books in association with the BMA

89 BMA Ethics (2009) The Medical Role in Restraint and Control; Guidance from the British Medical Association BMA http://www.bma.org.uk/images/medicalrolerestraintaug2009_tcm41-190278.pdf accessed 11 03 11

90 BMA Ethics (2009) Health care of detainees in police stations British Medical Association February 2009 http://www.bma.org.uk/ethics/detained_people/healthcaredetainees.jsp accessed 11 03 11

91 The Baha Mousa Inquiry (2010) Report by Vivienne Hilary Nathanson to the Baha Mousa Public Inquiry http://www.bahamousainquiry.org/linkedfiles/baha_mousa/module_4/expert_witnesses/vn/miv008998.pdf accessed 09 02 2011

92 The Baha Mousa Inquiry 18th May 2010 Oral Evidence http://www.bahamousainquiry.org/linkedfiles/baha_mousa/baha_mousa_inquiry_evidence/evidence180510/2010-18-05-day95fullday.pdf accessed 09 02 2011

93 Letter from the BMA to Medact February 4 2011

The GMC is the statutory body which determines standards of practice and is the body that has the power to limit an individual doctor's practice or remove them from the register.

The future and recommendations

The following recommendations recognise that the BMA and the GMC work closely together, but that any statutory action will have to be taken by the GMC.

We recommend that:

- the BMA/GMC should review the situation of training in medical ethics and the recognition of signs of torture to ensure that all doctors receive adequate training on this at the undergraduate and postgraduate level, including those working in prisons and detention centres. This would give practical effect to the recommendation of a report following a surprise inspection of Harmondsworth Immigration Removal Centre by the Inspector of Prisons which recommended that health care staff 'should receive specific training in the identification and management of detainees who have been tortured'. However this was the fourth time this had been recommended.

- there should be refresher courses and e-learning opportunities for military doctors in the field, so they can 'test their understanding of medical ethics' as recommended by Dr Vivienne Nathanson.
- the BMA should take all opportunities to emphasise that there is no delineation between 'moderate physical pressure', 'inhumane and degrading treatment' and 'torture', and ensure that the recommendations of the Declaration of Tokyo on torture are not eroded by erroneous definitions.
- The BMA should support the recommendation that 'any revision of the Declaration of Tokyo' should 'emphasise the importance of privacy and confidentiality in consultations between doctors and prisoners'⁹⁴, particularly as this could prevent future abuses and help to hold perpetrators to account.
- the BMA and health professional organisations should continue to be involved in campaigns to highlight abuses at detention centres and during the removal process, and collaborate with civil society organisations that have acted to prevent such abuse.⁹⁵
- the BMA/GMC should urgently investigate doctors' awareness of torture being carried out overseas, to produce information for British intelligence services.

94 O'Neill D (2009) Medical ethics and prisoners *The Lancet* Vol 373 March 14 2009

95 Birnberg Peirce & Partners (2008) Outsourcing Abuse: the use and misuse of state-sanctioned force during the detention and removal of asylum seekers. Medical Justice and the National Coalition of Anti-Deportation Campaigns

4. Italy

The present situation

In Italy, recent cases of medical complicity in torture have occurred in prisons and detention centres. In these contexts, often hidden from the public eye, it is extremely difficult to document episodes of ill-treatment. Nevertheless, it has been possible for some of them to be uncovered, primarily as a result of information from families and civil society organizations.^{96 97}

During the 27th G8 summit in 2001, 252 Italian and international demonstrators were arrested in a temporary detention centre in Bolzaneto, near Genova, and subjected to violence from the police and the army. Doctors and nurses who were on duty in the prison at this time were not only passive witnesses to this violence, they have been accused of playing an active role in it. In particular they have been accused of conducting physical examinations in a way that has been judged to be disrespectful of human dignity⁹⁸.

The arrested people suffered serious, systematic and protracted inhuman and degrading treatment at the hands of health personnel. This included being sutured without anesthesia; left undressed for long periods of time; and being hit and beaten. They were examined perfunctorily and no report was made of their injuries or what caused them⁹⁹. These facts came to light when two nurses, Marco Poggi and Ivano Pratisoli decided to speak out about what happened in Bolzaneto. Poggi subsequently had to leave his job as a prison nurse due to intimidation.

A more recent case is that of Stefano Cucchi, a 31-year-old man arrested in Rome on October 15th, 2009, who died one week after being admitted to the prison hospital. His family was not allowed to see him nor were they notified about his worsening condition until his death. When they finally saw his body, it showed clear signs of violence.

Publication of pictures of the corpse, authorised by the family, led to questions being asked about the responsibilities of the police agents and of the doctors and nurses who were on duty in the prison hospital

during the time he was an in-patient. In his final days he refused to drink and eat in protest against being prohibited from meeting his parents and his lawyer. The doctors did not question, investigate or report the lesions on his body that were later documented in the autopsy; “nor were his precarious physical conditions and his rights adequately protected”¹⁰⁰.

The Italian Federation of Medical Boards (FNOMCeO) & the Provincial Medical Boards

In theory, the Provincial Medical Boards are the statutory bodies for the compulsory registration of medical doctors, and are grouped within the Italian Federation of Medical Boards (FNOMCeO), the official body which coordinates the Provincial Boards. These Boards are in charge of medical licensing and of the control of Italian medical ethical conduct, sanctioning or expelling their members, so they should play a role in exposing and addressing medical complicity in torture. The FCOMCeO is not currently a member of the WMA.

Furthermore in the latest Italian code of medical ethics there is an explicit reference (article 50) to the prohibition to cooperate, to take part in or to be present during the practice of the death penalty, torture or other forms of cruel, inhuman or degrading procedures, although the WMA Declaration of Tokyo is not incorporated in its entirety.

Uncovering torture and the response

However, in the cases described above, the provincial Medical Boards acted to protect their members and reputation, did not take a clear position and simply relied on (but in the end ignored) the evidence and conclusions of the Bench. Individual doctors and/or civil society associations did speak out, and in a few cases even some local Medical Boards whose members were suspected of serious misconduct have taken a public position and tried to conduct internal investigations, but with no resulting sanction of these members' behaviour.

96 Centro Studi “Ristretti Orizzonti” press release November 2009 http://www.ristretti.it/areestudio/disagio/ricerca/eventi/dossier_casi_sospetti.pdf accessed 14 02 11

97 Ristretti Orizzonti, Dossier “Morire di carcere” (Die to jail) <http://www.ristretti.it/areestudio/disagio/ricerca/index.htm> accessed 14 02 11

98 State Attorneys' legal proceedings, Bolzaneto Trial http://www.supportolegale.org/files/memoria_pm_bolzaneto.pdf (Italian) accessed 10 08 10

99 Ibid

100 Parliamentary Court of Inquiry, Final Report on Inquiry relating to efficiency, effectiveness and pertinence of Stefano Cucchi's medical treatment March 17 2010 <http://www.senato.it/service/PDF/PDFServer?tipo=BGT&id=471997> accessed 10 08 10

The Genova Medical Board carried out an investigation by interviewing the medical chiefs responsible for Bolzaneto Emergency Rooms but did not conduct any inquiry into the role of the physicians at Bolzaneto¹⁰¹. To date, even though five doctors involved in the Bolzaneto case have been sentenced by two different courts, the FNOMCeO has made no public statement, nor has it applied sanctions: all five doctors remain registered professionals and none of them has been subject to any disciplinary measures.

In the case of the doctors involved in Cucchi's death, the local Medical Board held an extraordinary council meeting to address the issue, but no direct action has yet been taken to assess individual responsibilities.¹⁰² ¹⁰³ Concern has been expressed about the possible structural drivers behind the incident, however, and the case has been judged as a 'sentinel event' in the troublesome relationship between prisons and the health system.¹⁰⁴ Since November 2009, six doctors and three nurses involved in the case have been under investigation for several offences, including abuse of authority, false certification, abandonment of a helpless person, assisting professional offenders, and failure to report.¹⁰⁵ On January 2011 the examining magistrate took the decision to try them for the charges with the first court session scheduled for March 24th 2011.¹⁰⁶

In both the Bolzaneto and the Cucchi case, the role of civil society (victims' families, friends and/or civil society organizations) has been crucial in fostering and shaping the state's response, but there was little response from the general public.

Nevertheless, these minority groups have successfully built effective campaigns targeted at public institutions, resulting in the opening of investigations. The Bench, and, in Cucchi's case, the Italian Parliament, has played an important role in conducting the investigations, identifying responsibilities and handing down sentences. However, in Italy the crime of torture is not incorporated into domestic law so the sentences have

been weak. Moreover medical ethics norms are 'soft-law' acts and so they cannot be disciplined by the state but only by the Medical Boards, which can investigate and impose disciplinary actions such as suspending and striking off physicians who are judged to have contravened ethical codes.

The future and recommendations

Even if international pressure has been increasing¹⁰⁷ – accompanied by less influential but continued lobbying inside the country from organizations such as ACAT Italia (Azione dei Cristiani per la Abolizione della Tortura), Amnesty International Italy, and Doctors Against Torture – no substantial changes are in sight.

The first step should be made on the legal side, incorporating the crime of torture into domestic criminal law, as Italy pledged to do 20 years ago after signing and ratifying the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.¹⁰⁸ A second step, involving medical institutions and primarily the FNOMCeO, would then be crucial in order to prevent medical complicity in torture or ill-treatment. Effective actions could include the following:

- The FNOMCeO should become a member of the World Medical Association (WMA), in order to support WMA legitimacy, thus strengthening both international and local policies to fight torture.
- FNOMCeO and national authorities should cooperate to identify high risk situations.
- FNOMCeO should take action in order to apply sanctions (up to licence withdrawal) on all doctors who take part in, facilitate or allow torture.
- FNOMCeO should support (economically, legally and socially) doctors who speak out and refuse to participate in torture.
- Finally, the curricula of all institutions and professionals engaged in medical education should include issues related to human rights, medical ethics and medical complicity in torture.

101 G8-Doctor in the storm (G8.dottori nella bufera), Genova Medica 9/2001. www.omceoge.org/bollettino/200109.pdf accessed 26 08 10

102 Rome Medical Board, Bulletin year 62-n.3-may/june 2010 http://www.ordinemediciroma.it/OMWeb/Files/Bollettini/Bollettino_79.pdf, accessed 07 12 10

103 Rome Medical Board, News May 5th 2010 http://www.ordinemediciroma.it/OMWeb/Asp/News_cat.asp?Cat=ord accessed 14 02 11

104 Ibid

105 La Repubblica-Roma January 25th 2011 http://roma.repubblica.it/cronaca/2011/01/25/news/il_caso_cucchi_12_a_giudizio_e_una_condanna_a_2_anni_agi_-_roma_25_gen_-_per_la_morte_di_stefano_cucchi_il_gup_rosalb-11629464/index.html?ref=search accessed 14 02 11

106 BMJ News (2011) BMJ 2011; 342:d702 <http://www.bmj.com/content/342/bmj.d702.full> accessed 08 02 11

107 UN Committee Against Torture, Conclusions and Recommendations, Italy, July 16 2007. CAT/C/ITA/CO/4 <http://unhcr.org/refworld/country,,CONCOBSERVATIONS,ITA,,46a0b8372,0.html> accessed 11 03 11

108 UNTC, Status as at 10/08/10 of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (New York, 10/12/1984) http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&lang=en accessed 10 08 10

5. Israel

The present situation

Medical complicity in practices amounting to torture occurs during interrogation of Palestinian detainees conducted by the Israel Security Agency (ISA) or shabak. Doctors treating Palestinian detainees and prisoners are employed directly by the Israel Prison Service (IPS) or via subcontractor companies. They do not enter the shabak's interrogation wings, but detainees are routinely brought to them for medical examination or treatment before, during and after interrogations – including those involving abuse or torture.

Medical files and detainees' testimonies demonstrate that health professionals consistently fail to oppose, accurately document and report evidence or suspicion of torture of detainees they examine and treat, and in some cases refuse to do so at the request of prison personnel.^{109 110 111} Moreover, doctors provide medical information about detainees directly to their interrogators.¹¹² Outside the prisons, hospital staff receiving patients from detention facilities who exhibit evidence of abuse consistently fail to identify and document the suspected cause of injury or report suspicions of torture.¹¹³

In addition to complicity in Israeli practices amounting to torture, doctors employed at detention facilities holding asylum seekers (chiefly from Sudan and Eritrea) fail to document or respond to evidence of rape and torture that their patients have undergone in their home countries or on their way to Israel. The result is late pregnancy terminations and failure to offer rehabilitation of torture victims.¹¹⁴ Physicians for Human Rights (PHR)-Israel's Open Clinic has recorded numerous testimonies of torture from asylum seekers, as well as almost 100 pregnancy terminations requested by women asylum seekers visiting the clinic in the first half of 2010, mostly due to rape en route to Israel.

An opinion was given by an Israeli court defining asylum-seekers on their way to Israel as victims of trafficking (26.08.2010, Hebrew, unpublished). PHR-Israel has sent letters to the medical authorities at the IPS and to relevant ministries, pointing to a lack of awareness of torture among authorities and requesting that a body be established to ensure that doctors at detention facilities as well as all other relevant officials receive training and guidelines for identification and response to torture and rape victims (26.04.2010, 13.10.2010, Hebrew, unpublished). The response so far has been inadequate.

Systemic failures compromising the doctors' ability to protect their patients include the following:

- Doctors in the prison system are employed by the IPS and the Ministry of Public Security, and not by the Ministry of Health (MoH), limiting doctors' independence and the ability of the MoH to supervise and enforce proper conduct according to medical considerations.
- IPS doctors are not permitted as a rule to become members of the Israel Medical Association (IMA) due to IPS limitations on unionising, and they may meet IMA representatives only if permitted by IPS.
- There are no MoH guidelines for identification, documentation and reporting of torture by medical professionals.
- Although the right of inmates to be examined by an external doctor is enshrined in Israeli law and IPS regulations, the shabak prohibits such visits while inmates are in the interrogation wings. A recent example was the case of Ameer Makhoul, a Palestinian citizen of Israel who was interrogated in May 2010. The shabak rejected a request by PHR-Israel to visit him, stating that it objected in principle to external doctors' visits during interrogations.¹¹⁵

109 Public Committee Against Torture in Israel (PCATI) (2007) Ticking Bombs: Testimonies of Torture Victims in Israel pp27-28, 35-36, 53, 79-80. <http://www.stoptorture.org.il/files/pcat%20new%20web%20file%20eng%20light.pdf> accessed 02 12 10

110 Even D (2010) Health Ministry, Israel Medical Association probing whether physicians failed to report torture of Palestinian detainee. Haaretz <http://www.haaretz.com/print-edition/news/health-min-israel-medical-association-probing-whether-physicians-failed-to-report-torture-of-palestinian-detainee-1.266495> accessed 02 12 10

111 Physicians for Human Rights-Israel (PHR-Israel) (2010) Physicians' Involvement in Torture – the Mughrabi case <http://www.phr.org.il/default.asp?PageID=116&ItemID=600> accessed 02 12 10

112 See below, Uncovering torture and the response, and Note 22.

113 PHR-Israel and PCATI letter to the Israeli Ministry of Health, 07.03.2010 pp. 5-10. http://www.phr.org.il/uploaded/Mugrabi_Ministry%20of%20Health_eng%2017%203%2010.pdf accessed 02 12 10

114 PHR-Israel information submitted to the Committee on Economic, Social and Cultural Rights (CESCR), October 2010, pp. 14-15 www2.ohchr.org/english/bodies/cescr/docs/ngos/PHR_Israel45.doc accessed 02 12 10

115 PHR-Israel Motions to Allow a Doctor Examine Ameer Makhoul and Obtain His Medical Records <http://www.phr.org.il/default.asp?PageID=116&ItemID=689> accessed 02 12 10

Uncovering torture and the response

Reports of torture in Israeli detention facilities go back to shortly after the 1967 war.

In 1987 a government commission found evidence of routine use of force during interrogations. However, rather than banning torture, the commission officially regulated and sanctioned specific measures, defined as ‘moderate physical pressure.’¹¹⁶ Although the details of the regulations were kept secret, their introduction was followed by widespread and consistent reports of beatings, prolonged tying in painful positions and violent shaking [Heb. *tiltulim*] of the head and torso.¹¹⁷

These measures, sanctioned by the government and used systematically, were defined as torture by the UN Committee Against Torture (UNCAT).^{118 119 120} Abd al-Samad Harizat died in April 1995 after violent shaking. After his death, PHR-Israel and the Public Committee Against Torture in Israel (PCATI) sought an injunction against shaking, with no results. Harizat’s case in which the violent shaking of the head and torso of a detainee led to a subdural haemorrhage which resulted in his death^{121 122} brought the issue to mainstream public debate and a long battle for the outlawing of torture was fought in the courts.

This continued until 1999, when a High Court ruling prohibiting torture outlawed specific forms of abuse used in Israel. But it left a loophole whereby interrogators were able retroactively to avoid criminal responsibility by invoking ‘ticking bomb’ situations in court¹²³ (see Introduction). Despite the ruling, reports by NGOs^{124 125} and UNCAT¹²⁶ point to a recent rise in the use of practices amounting to torture and/or cruel, inhuman or degrading treatment in Israeli detention facilities. Furthermore, Israeli authorities have ensured immunity for shabak employees through legislation of the Israel Security Agency (ISA) Law (2002), and have admitted using the ‘necessity defence’ to permit special measures in interrogations.¹²⁷ In Israel, there is currently no domestic legislation prohibiting torture, as defined by the UN,¹²⁸ and no interrogator against whom allegations of torture have been made has been prosecuted.¹²⁹

Before 1999, doctors’ involvement was clearly documented not only in medical files but also in the State’s response to a petition submitted to the Israeli High Court of Justice.¹³⁰ According to this, all shabak interrogation centres were staffed by physicians 24 hours a day in order to provide immediate medical care, thus allegedly reducing the risk of damage that might occur as a result of violent shaking.¹³¹

116 The Landau Commission (1987) State of Israel: Commission of Inquiry into the methods of investigation of the General Security Service regarding Hostile Terrorist Activity. Report, Part One, Jerusalem October 1987

117 Amnesty International (1996) Under constant medical supervision: Torture, ill-treatment and the health professions in Israel and the OPT. AI Index: MDE 15/037/1996 <http://www.amnesty.org/en/library/asset/MDE15/037/1996/en/b425cd69-eafb-11dd-aad1-ed57e7e5470b/mde150371996en.pdf> accessed 11 03 11

118 UNCAT, A/49/44, Concluding observations of the Committee against Torture: Israel, paras 159-71. 12 June 1994. <http://www.unhcr.ch/tbs/doc.nsf/0/a8dc0b9a636a7a36c12563e20033f2e4?Opendocument> accessed 11 03 11

119 B’Tselem (1998) Torture as a Routine: The Interrogation Methods of the General Security Service Jerusalem <http://www.btselem.org/english/publications/index.asp?TF=20> accessed 02 12 10

120 Amnesty International (1998) Israel/Occupied Territories and the Palestinian Authority: Five years after the Oslo Agreement: human rights sacrificed for ‘security’ (1998). <http://www.amnesty.org/en/library/asset/MDE02/004/1998/en/7090ae54-d9de-11dd-af2b-b1f6023af0c5/mde020041998en.pdf> accessed 02 12 10

121 Amnesty International (1995) Israel and the Occupied Territories: Death by shaking: the case of Abd al-Samad Harizat, AI Index: MDE 15/23/95

122 Physicians for Human Rights (1995) Israel and the Occupied Territories: Shaking as a form of torture. Death in custody of Abd al-Samad Harizat, a Medicolegal Report. PHR Boston October 1995 ISBN 1879707-19-5

123 B’Tselem (1999) Torture and ill-treatment as perceived by Israel’s High Court of Justice http://www.btselem.org/english/Torture/HCJ_Ruling.asp accessed 02 12 10

124 B’tselem and HaMoked, (2007) Absolute Prohibition: The Torture and Ill-Treatment of Palestinian Detainees 2007. http://www.btselem.org/Download/200705_Utterly_Forbidden_eng.doc accessed 02 12 10

125 Defence for Children International/Palestine Section (2009) Palestinian Child Prisoners: The systematic and institutionalised ill-treatment and torture of Palestinian children by Israeli authorities. June 2009. <http://www.dci-pal.org/english/publ/research/CPRreport.pdf> accessed 02 12 10

126 UN CAT (2009) Concluding observations of the Committee against Torture : Israel, 23 June 2009, CAT/C/ISR/CO/4. <http://www.unhcr.org/refworld/docid/4a85632b0.html> accessed 11 03 11

127 Ibid, para. 14., “According to official data published in July 2002, 90 Palestinian detainees had been interrogated under the “ticking bomb” exception since September 1999.” In 2008 a group of Israeli human rights groups requested that then-Prime Minister Ehud Olmert be imprisoned for contempt of the court for using the ‘necessity defence’ in advance instead of in retrospect, giving prior authorization to prohibited measures in violation of the 1999 ruling. The request was rejected by the court in 2009 for procedural reasons (Heb.: <http://www.acri.org.il/pdf/petitions/hit5100biz.pdf> accessed 11 03 11)

128 Ibid, para 13.

129 Ibid, para 21.

130 Physicians for Human Rights-Israel (1999) Physicians and Torture – The Case of Israel Tel Aviv. PHR-Israel 1999

131 Ibid, p.11.

Moreover, in the 1990s, PHR-Israel exposed various 'medical fitness forms' used in interrogation centres, in which doctors were required to certify whether detainees would be able to withstand specific types of abuse and torture.¹³² These forms were discontinued in 1999, but PHR-Israel has recently exposed a similar practice in which doctors continue to record the results of medical examinations and medical information about detainees on official forms that are addressed explicitly to 'the interrogator.' On 20 July 2010 a letter was sent by PHR-Israel to the Israeli Ministry of Health regarding eight examples of such forms, collected between 2003 and 2009, with no response to date.

The Israel Medical Association

Most Israeli physicians are members of the Israel Medical Association (IMA), which is defined as 'the official workers' organisation representing physicians in Israel'.¹³³ The IMA comprises three main elements:

- a professional organisation representing Israeli physicians' interests and providing them with medical insurance, legal assistance and other services;
- a scientific committee which is the statutory body responsible for specialty training and registration, as well as recognition of institutions for training purposes;
- an ethics bureau responsible for setting out ethical guidelines for doctors, advising doctors on ethical issues, and promoting public health policies through public outreach, lobby and legislation initiatives. Unlike for the BMA or the AMA, this responsibility also extends to investigating and to establishing hearings to determine whether breaches of such ethical codes have occurred.

Licensing of doctors in Israel is the responsibility of the Ministry of Health (MoH).

The IMA's response to allegations of torture has been weak. Before 1999 it accepted the argument of the State according to which the physical measures used against detainees did not amount to torture.¹³⁴ In 1999, PHR-Israel representatives held a meeting with Dr Yoram Blachar and Professor Eran Dolev of the IMA and the Chief Medical Officer of the Israel Police. The latter requested ethical guidelines and a

statement about whether a medical examination before, during and after an interrogation constituted participation in torture.

The IMA's leaders responded that before answering these questions, they had to decide whether the IMA believed that 'moderate physical pressure' constituted torture. Until the High Court ruling the IMA failed to respond to this question. It asked to be allowed to wait for the High Court ruling on this matter before acting, and refused to issue guidelines prohibiting physicians from working in shabak facilities. After the 1999 ruling made the use of torture in Israeli prisons illegal, the IMA claimed that it could not take action against guilty physicians since it did not have specific names. It did not initiate its own examination of the conduct of prison doctors.

The IMA's leaders' public statements reflected positions that do not unequivocally reject torture:

- IMA Ethics Bureau Chairman Professor Eran Dolev gave an interview to Neri Livneh of the newspaper Ha'aretz on 29 January 1999, explaining that 'not every presence in a GSS [shabak] facility means participation in torture... besides, we do not live in a country named Utopia. As a citizen, I can understand that these things are a necessity for the state of Israel'. Dolev conceded that the problem was a lack of guidelines, but indicated a preference for a different kind of action: 'I know the right people and I can speak to them, and this brings about results. A week ago, the issue of the more comfortable handcuffs and the ventilated sack was publicized. Who do you think was behind that?' he asked the journalist.
- On 15 November 1999, after the ruling by the High Court of Justice, IMA chairman Dr Yoram Blachar published an Op-Ed in Ha'aretz in which he referred to the use of 'moderate pressure' during interrogations as a practice from the dark ages. He indicated that 'now, perhaps belatedly, these physicians [who work in the prison] can join the community of physicians... who have already adopted the ethical codes, and report to the IMA any deviation from norms of behavior, which have finally been legitimized by the High Court of Justice.' Even in this article, however, in which he

¹³² Ibid, Appendices A, B & C; see also Amnesty International 1996. The forms were first exposed in 1993, then allegedly discontinued, only to be exposed again in a different form in 1997.

¹³³ Welcome to the Israeli Medical Association <http://www.ima.org.il/en/CategoryHome.asp?cat1=159&id=159&tbl=tblCategoryabout&level=1> accessed 02 12 2010

¹³⁴ In a letter to the Lancet (03.09.1997), IMA Chair Dr. Yoram Blachar erroneously claimed that moderate physical pressure conformed to international law, while reiterating the organization's commitment to the Tokyo Declaration

endorsed the ruling prohibiting torture, Blachar made sure to leave a loophole allowing harm to interrogated persons to continue: 'I have no doubt that in circumstances in which exertion of pressure, as opposed to torture, is justifiable in view of the existence of a 'ticking bomb', before the Attorney General or the Court, treatment will be determined by the special circumstances.'

Following the previously mentioned reports by PCATI, B'Tselem and HaMoked of the renaissance of torture, PHR-Israel contacted the IMA, asking that investigations be opened against doctors implicated by the reports. After prolonged pressure from PHR-Israel, the IMA requested that specific complaints be formally submitted to Ethics Bureau Chairman Professor Avinoam Reches before steps could be taken – a procedure subsequently followed by PHR-Israel. As early as 1993 the IMA claimed that to take a proactive role would be to 'get involved in politics, 'that they could only act in response to specific complaints, and that they had received none'.¹³⁵ Following a meeting in 2009 and coverage of the issue in medical literature in the UK,¹³⁶ the IMA claimed to have held an investigation into the allegations, and to have found that no doctors were complicit in torture.¹³⁷

The IMA investigation, however, consisted of a single telephone conversation with each of the physicians suspected of being involved in torture. The IMA did not ask to see the medical files from the interrogations, and made no comment on medical documentation made available to it, that showed that tortured persons had been examined by some of the physicians mentioned in the complaints. The IMA's argument was that in cases of alleged torture it is 'the victims' word against that of the physicians, and there is no way to decide between them.'¹³⁸

The attitudes reflected in the IMA's conduct are also reflected in an ambiguous paragraph in its ethical guidelines,¹³⁹ stating that when dealing with hospitalized inmates or alleged criminals, the defence of medical ethics offered to them is not absolute and some 'greater good' to society at large may require its compromise. In case of doubt, say the guidelines, the doctor should apply to the judicial system, which will determine the correct balance.

Positive developments include the fact that in 2007, the IMA reiterated its commitment¹⁴⁰ to the Declaration of Tokyo, and published an on-line course for doctors working in prisons.¹⁴¹ However, to date, no medical professional has been charged with any offence related to medical complicity in torture. Furthermore, reports continue to emerge alleging involvement of doctors in torture contrary to the stipulations of the Tokyo Declaration.¹⁴²

The future and recommendations

In late 2009 Dr. Leonid Eidelman was elected as the new IMA chairperson. He wrote in a letter to PHR-Israel that participation in torture is a criminal offence that should be reported to the police.

- Following this clear denunciation of doctors' complicity in torture concrete steps should be taken by the IMA, as well as legislation by the MoH. Until torture is completely prohibited by Israeli legislation and the shabak can demonstrate that it no longer practises it, doctors should be instructed by the IMA not to work in facilities where the shabak conducts its interrogations.
- Legislation should be introduced that will make it compulsory to oppose, document and report torture, as well as creating effective mechanisms for protecting whistleblowers. PHR-Israel has asked the

135 Amnesty International (1996) Under constant medical supervision: Torture, ill-treatment and the health professions in Israel and the OPT. AI Index: MDE 15/037/1996 <http://www.amnesty.org/en/library/asset/MDE15/037/1996/en/b425cd69-eafb-11dd-aad1-ed57e7e5470b/mde150371996en.pdf> accessed 11 03 11

136 Yudkin (2009) The Israeli Medical Association and doctors complicity in torture *BMJ* 2009; 339:b4078 <http://www.bmj.com/content/339/bmj.b4078.extract> accessed 02 12 10

137 Physicians for Human Rights-Israel (2009) Torture in Israel and Physicians' Involvement in Torture p10 Tel Aviv <http://www.phr.org.il/uploaded/PositionPaperTortue.pdf> accessed 02 12 2010

138 Ibid, pp. 10-11.

139 IMA (2006) Cooperation between medical institutions and law enforcement authorities <http://www.ima.org.il/MainSite/ViewCategory.aspx?CategoryId=1104> accessed 02 12 10

140 IMA (2007) Prohibition of Physician Participation in Interrogations and Torture <http://www.ima.org.il/en/CategoryIn.asp?show=Categories&id=317&tbl=tblCategoryabout> accessed 02 12 10

141 IMA <http://www.ima.org.il/MainSite/ViewCategory.aspx?CategoryId=2771> accessed 02 12 2010 composed by the Norwegian Medical Association, translated into Hebrew and adopted by PHR-Israel [Heb]

142 Fogelman S. (2010) Winning on points. *Haaretz* 9 July 2010. <http://www.haaretz.com/weekend/magazine/winning-on-points-1.300971> accessed 02 12 10

IMA and the MoH to initiate such legislation and has developed guidelines¹⁴³ that it has asked them to adopt and use among all medical personnel, with special attention to those in detention facilities. No response has been received to date.

- Medical personnel should be contractually independent from the security authorities and employed by the MoH, something which has been proposed by PHR-Israel for more than a

decade¹⁴⁴. The MoH has thus far turned a blind eye to allegations of doctors' complicity with torture, and its position should be challenged by the IMA. Whether the MoH will be able to act depends on the extent to which it – as well as the IMA – is willing and able to stand up to the much stronger Prime Minister's Office (under which the shabak functions) and the Ministry of Public Security (under which the IPS functions).

143 PHR-Israel (2008) Guidelines <http://www.phr.org.il/uploaded/PreventTorture.pdf> accessed 02 12 10

144 PHR-ISRAEL(2008) Oversight and Transparency in the Israeli Penal System

<http://www.phr.org.il/uploaded/%D7%93%D7%95%D7%97%20%D7%A9%D7%A7%D7%99%D7%A4%D7%95%D7%AA%20%D7%95%D7%91%D7%A7%D7%A8%D7%94.pdf> accessed 07 06 11

Conclusions and recommendations

Conclusions

These conclusions and recommendations are made in the light of this report being ‘work in progress’. Nevertheless, these case studies and other recent reports cited are clear evidence that there is still much to be done both to protect medical professionals who expose torture, and to prevent medical complicity in torture.

This is despite the many declarations outlined above, including the UN’s Istanbul Protocol and the WMA Declarations of Tokyo and Hamburg (endorsed by member NMAs), which declare the illegality of torture and provide clear ethical codes forbidding the involvement of medical staff in torture and encouraging protection for whistleblowers. There is still a clear gap between ethical codes and medical practice, and we first summarise why this might be.

NMAs may be less proactive and responsive than is required by the WMA Declarations because:

- Some NMAs, such as the BMA, are not statutory bodies and therefore there is no statutory requirement to investigate allegations of torture, or to report their findings;
- For many NMAs the resources to so act are inadequate, or are claimed to be so, particularly in times of financial constraint;
- In certain situations, particularly in societies which have experienced recent internal violent conflict and a legacy of societal vengeance, those in power may lack the political will to oppose torture, or actually favour the coercion of information from detainees by violent methods. They may also condemn those who oppose torture. This will be a challenging environment for both individual medical professionals and NMAs, particularly if there is a level of societal acceptance of torture.

Individual doctors may not conform to the ethical codes of their profession because:

- Some medical professionals may fear losing their job, or even fear for their personal or family safety, if they refuse to comply with torture. This is particularly relevant where the medical professional is in a situation of ‘dual loyalty’ often encountered in military service or during employment in a prison;
- There may be a general lack of awareness, knowledge and training in medical ethics and the Hippocratic tradition, and in international law, at the undergraduate and postgraduate levels;
- Some medical professionals may be influenced by their position on one side of a conflict, and abandon their medical impartiality, ethical codes and compliance with international law as a result.

The WMA may, in trying to fulfil its role as a global body sensitive to the needs of its individual component NMAs, feel constrained in vigorously pursuing its ethical codes by:

- Its own (democratic) constitution;
- Its concern to protect rather than censure doctors;
- As the WMA is a non-statutory body, the absence of any statutory responsibility for it to investigate allegations of medical complicity in torture, and to report its findings;
- For the same reason, the absence of any statutory responsibility for the WMA to protect individual medical ‘whistle-blowers’ witnessing or diagnosing torture and reporting their findings to relevant authorities;
- The power structure within the international community.

Recommendations for the World Medical Association

i) Improve education

The WMA should work with NMAs to promote wider dissemination of relevant educational materials to the medical professions through all appropriate media, including on-line. Materials should emphasise the ethical and professional duty to persist in the face of scepticism, opposition or outright authoritarian denial, and make links to international law. They should also include practical diagnosis manuals such as the recent Atlas of Torture from the Human Rights Foundation of Turkey.

The WMA should offer to assist any NMA encountering resistance to incorporating adequate training on medical ethics and the diagnosis of torture in undergraduate and postgraduate curricula. The WMA should develop an oversight of training needs, and encourage NMAs to develop, disseminate and incorporate training in countries where this does not exist.

ii) Promote professional confidence

The WMA should continue to promote the ethical principles underlying refusal to participate in torture. The WMA should work with NMAs to reinforce or develop safe confidential systems for reporting torture, and to establish protective mechanisms for those who might be at risk, giving particular attention to medical professionals working in situations of dual loyalty. The WMA should also promote, and where necessary develop, its own systems for providing confidential advice to medical professionals fearing reprisal or encountering hostility because of their action on evidence of torture.

iii) Support amendment to War Crimes Act

The WMA should support the recommendation by Physicians for Human Rights to amend the War Crimes Act in order to criminalise unethical experimentation on people, and to ensure consistency with the Geneva Conventions.¹⁴⁵

iv) Build on collaboration with human rights bodies to ensure sanctions on medical complicity

The WMA should build on their work with the UN Human Rights Council and the Special Rapporteur on Torture, to assist NMAs in developing and reinforcing systems of enquiry into allegations of medical complicity in torture, and systems that

conform to international law for administering fair justice to those alleged and found to have been guilty in such acts of medical complicity. Support to NMAs in this process should include concrete recommendations on what action they should take, and appropriate follow up.

v) Refer cases to the Special Rapporteur on Torture

The WMA should establish a clear system for referring cases to the UN Special Rapporteur on Torture as part of the UN's collaboration with the WMA to ensure clear links with international law and international legal processes. Particular attention needs to be given to cases that are referred to the WMA by other than the NMAs concerned, and when the NMAs concerned are constrained in some way in investigating the cases themselves. The WMA should encourage NMAs to raise cases with the Special Rapporteur when they consider this is appropriate but the NMA is not taking action.

vi) Refute the validity of the 'ticking bomb' scenario

The WMA should take a clear position on the 'ticking bomb' scenario by restating the case that torture, which includes 'moderate physical pressure', under any circumstance is unacceptable and drawing attention to the weaknesses of the 'ticking bomb' rationale.

vii) Increase the network of international organisations

By collaborating with a wide range of actors on the basis of ethics and rights the WMA can help to counter international political and military agendas which distort and cloud the issue of torture prevention. Collaboration with experienced human rights organisations at all levels would be particularly valuable.

viii) Transparency and information sharing on medical opposition to, and complicity in, torture

Subject to confidentiality and security considerations for both patients and physicians, the WMA should make reports of cases of medical opposition to, and complicity in, torture freely available. These should be regularly updated so experiences can be shared and principles of transparency and learning respected.

¹⁴⁵ Physicians for Human Rights, Experiments in Torture: Evidence of Human Subject Research and Experimentation in the "Enhanced" Interrogation Program, 2010.

Recommendations for National Medical Associations

There is a variety of regulatory, administrative and political arrangements in the countries of the different NMAs, so specific recommendations may not always be appropriate. Different NMAs will also be at various stages of developing procedures, and work in different political and security environments. The following recommendations are based on common principles.

i) Promote medical education

In collaboration with the WMA, each NMA should vigorously promote medical education on the nature of torture, the implementation of the established ethical codes not to participate or comply with it, and related international law. Each NMA should ensure that undergraduate and postgraduate curricula include adequate training on the diagnosis of torture, the professional, ethical and legal necessity to report suspected cases, and requests to be complicit, to the relevant authorities. They should also ensure that sufficient materials and advice are available to the medical workforce, including doctors associated with the military, custodial and security forces, and that systems are in place to allow actual cases to contribute to evidence-based learning.

ii) Guarantee safety and confidentiality

In collaboration with the WMA, each NMA should work vigorously to guarantee a safe, secure confidential system for those medical personnel who are worried about documenting or speaking out about torture. This system should also take account of the security of their families, and particularly those medical personnel working in situations of 'dual loyalty'. NMAs should also develop referral systems through which medical professionals wishing to make such reports can be supported, including by the WMA, if the national environment puts them at risk. These referral systems should be able to accept reports from those outside the profession, or through other trusted organisations. NMAs should consider creating a fund for financial support for medical professionals where speaking out has resulted in loss of income or livelihood, or the need to pay legal costs.

iii) Develop sanctions on medical complicity

NMAs should develop or strengthen – with the assistance of the WMA as needed – systems of enquiry into allegations of medical complicity in torture, and systems for administering justice to those

alleged and found to have been guilty in such acts of medical complicity. Links with human rights organisations at national and international level – where appropriate through the WMA – should be used to reinforce these procedures, particularly where there is a difficult national environment.

iv) Provide assistance to support doctors in situations of 'dual loyalty'

It is known that medical professionals working in prisons and detention centres are in situations of 'dual loyalty' and a system should be provided which they can use if they are in need of support. This should include the possibility of the NMA receiving reports in confidence from a range of actors including the doctors themselves and others they work with, victims of torture, relatives and friends.

v) Work to make torture unacceptable

NMAs should work with civil society and legal and political institutions in their countries to develop societal understanding of the unacceptability of torture. As well as the legal and ethical arguments, the corrosive effects that an acceptance of torture has on perpetrating individuals and on society, and the unreliability of evidence gained under duress should be emphasised. NMAs should work towards a public understanding that all forms of torture are unacceptable, including 'moderate physical pressure' and 'inhuman and degrading treatment', and that there are no exceptional circumstances in which these can be accepted. NMAs should where appropriate call to account the entertainment industry in relation to these issues, and the effect this can have on general opinion. International collaboration and mutual support among NMAs may be helpful.

vi) Build on collaboration with the UN Special Rapporteur on Torture

The role for the Special Rapporteur on Torture (currently Juan Mendez, in the Office of the High Commissioner on Human Rights) could be developed to include:

- assistance with the investigation of NMAs as necessary
- the sanctioning of individual doctors, in collaboration with the WMA and the NMA as necessary
- collaboration with the WMA to ensure clear links with international law and international legal processes.

In conclusion

The WMA has played an influential role in the development of ethical practices in an increasingly complex clinical, legal and political environment, and acted as an essential agent for enhancing the safety and security of citizens throughout the world – particularly in areas of violent conflict. It has a vital role to play in improving the medical skills needed to document and treat the consequences of torture, and

ensuring non-compliance in such activities. We also see the WMA as an essential agent in the promotion of increased security and support for medical practitioners and their associates who witness and speak out about cases of torture. We request that these recommendations be considered at the 188th session of the WMA General Assembly in October 2011.



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