

Doctors' involvement in torture

Jesper Sonntag, MD*

Abstract

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

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

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

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

Introduction

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

*) Region Sjælland
Denmark
jespersonntag@hotmail.com

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

Objectives

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

Methods

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

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

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

Material

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

Why doctors are involved in torture

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

Doctors at risk

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

Dual loyalty

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

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

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

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

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

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

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

Discussion

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

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

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

The U.N.,²⁷ World Medical Association

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

How and when doctors participate in torture

Interviews with torture survivors – literature

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

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

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

The study showed that 42 torture survi-

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

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

Interviews with doctors

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

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

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

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

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

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

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

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

Results (Table 1)

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

Table 1. Results from the five studies.

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

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

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

*: Results given from the original articles.

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

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

The results were:

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

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

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

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

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

Discussion

Doctors involvement according to testimonies from torture survivors

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

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

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

resent torture survivors outside the Middle East.

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

Doctors’ involvement according to testimonies from doctors

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

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

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

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

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

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

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

would characterise these examples as torture.

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

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

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

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

Classification model

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

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

Before torture – diagnosis:

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

Before torture – treatment:

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

During torture – diagnosis:

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

During torture – treatment:

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

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

During torture – direct participation:

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

During torture – indirect participation:

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

After torture – diagnosis:

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

suspects that torture has occurred but does not report it.

After torture – treatment:

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

After torture – falsification of journals, certificates or reports:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Acknowledgement: Bent Sørensen, Professor, MD, DMSc; RCT Documentation Centre; Region Sjælland

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