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ANALYSIS

Clinical care and complicity with torture

In the light of US Central Intelligence Agency guidelines that limited routine care of detainees to promote torture, **Zackary Berger and colleagues** call for sanctions against health professionals who cooperate

Zackary Berger *associate professor*[1 2], Leonard S Rubenstein *senior scientist*[2 3 2 3], Matthew DeCamp *assistant professor*[1 2 1 2]

[1]Johns Hopkins School of Medicine, Division of General Internal Medicine, Baltimore, MA, USA; [2]Johns Hopkins Berman Institute of Bioethics; [3]Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health; Correspondence to: Z Berger zberger1@jhmi.edu

The UN Convention against Torture defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person" by someone acting in an official capacity for purposes such as obtaining a confession or punishing or intimidating that person.[1] It is unethical for healthcare professionals to participate in torture, including any use of medical knowledge or skill to facilitate torture or allow it to continue, or to be present during torture.[2-7] Yet medical participation in torture has taken place throughout the world and was a prominent feature of the US interrogation practice in military and Central Intelligence Agency (CIA) detention facilities in the years after the attacks of 11 September 2001.[8-11] Little attention has been paid, however, to how a regime of torture affects the ability of health professionals to meet their obligations regarding routine clinical care for detainees.

The 2016 release of previously classified portions of guidelines from the CIA regarding medical practice in its secret detention facilities sheds light on that question. These show that the CIA instructed healthcare professions to subordinate their fundamental ethical obligations regarding professional standards of care to further the objectives of the torturers.[12]

This document adds yet another disturbing element to our understanding of medical complicity in torture, suggesting a need to strengthen international and domestic ethical declarations to promote accountability for such complicity.[13] As an executive order by the US President outlines continued transfer of prisoners to Guantanamo Bay,[14] and the President has not ruled out the use of torture, a response becomes all the more urgent.

Medical guidelines on enhanced interrogation

From 2002, the CIA operated secret overseas prisons where terrorism suspects were detained and interrogated using "enhanced" methods such as extended sleep deprivation, confinement in a small box, exposure to cold water and air, stress positions, and waterboarding. CIA's Office of Medical Services issued guidelines in 2003 and 2004 for medical officers (physicians, physicians' assistants, and nurse practitioners). Medical officers were told that they were responsible for ensuring that enhanced interrogation methods did not result in serious or prolonged physical injury or death, although the limitations still permitted practices widely recognised as torture.[10 11] These guidelines were made publicly available in redacted form in 2009.

The 2016 release includes previously classified information related to medical monitoring and examinations that facilitated torture, such as evaluating prisoners for evidence of cardiopulmonary disease, assessing the gag reflex, and keeping prisoners nil by mouth before waterboarding. In addition, the release made it clear for the first time that CIA directions covered routine clinical care, showing that official policy limited clinical care for the sake of torture.

Limitations on clinical care

The guidelines stated that medical officers had an "obligation to maintain the highest professional and ethical standards and deliver appropriate care," and that they "should never perform or threaten to perform a medical procedure or intervention that is not medically indicated." Examples below, however, show how the guidelines directed clinicians to abrogate this ethical commitment.

Initial history and physical examination

Limitations imposed by the CIA on healthcare professionals' clinical decision making began early in the detention of terrorism suspects. For instance, the initial history and physical examination was expected to take no longer than 15 minutes and to focus only on recent trauma. At the same time, medical officers were required to conduct non-clinical functions, including body cavity searches of the oral cavity, head, and area behind the scrotum and rectum.

Ongoing medical care and treatment

Once a suspect was detained, and after a comprehensive physical examination to "address in-depth any chronic or previous medical problems," the guidelines set out requirements for and limitations on ongoing medical care. They allowed for periodic medical checks and treatment for chronic conditions, but they

also made clear that ongoing medical treatment "should not undermine the anxiety and dislocation that the various interrogation techniques are designed to foster" and "should not appear overly attentive." Furthermore, "time rigid administration of medications"—as might be required for treatment of thyroid disease, blood pressure, or many other chronic conditions—was to be avoided because such regular treatment might undermine one of the goals of interrogation: depriving detainees of their sense of the passage of time.

Nutrition

Healthcare professionals were required to force feed or hydrate hunger strikers whose body mass index fell below certain thresholds. The guidelines advocated using rectal rehydration as a "first line intervention," although it is not a recognised medical procedure. It can be painful, given that, as the guidelines state, the tube needs to "be inserted deep enough to prevent escape of the infused fluid."[12]

The guidelines also encouraged deceiving detainees by hiding medications and nutritional supplements in basic food, presumably when a suspect refused these medications. Force feeding is inhuman and degrading,[15] and over-riding an individual's free and informed decision to refuse medications violates respect for autonomy, one of the most fundamental principles of medical ethics.

Were the guidelines followed?

The extent to which the guidelines were implemented in the secret detention facilities is not known because medical practices remain classified. There is, however, evidence that medical staff at secret detention facilities followed at least some of the practices set out in the guidelines even before the guidelines were written.

The executive summary of the report of the US Senate Select Committee on Intelligence on CIA detention and interrogation practices shows, for example, that one detainee, Abu Zubaydah, had a bullet wound at the time of his capture that required surgery. Before his wound healed, he was "kept naked, fed a 'bare bones' liquid diet, and subjected to the non-stop use of the CIA's enhanced interrogation techniques," including waterboarding.[11 16] But medical staff provided "absolute minimum wound care (as evidenced by the steady deterioration of the wound)."[11] According to other CIA documents, interrogators consulted with medical staff to devise a means to require Zubaydah to clean his own exposed wound without disrupting the interrogation. Medical staff were also instructed to use goggles to conceal their facial features, using hand gestures further to conceal their identities "to diminish [the detainee] as an individual."[11]

The Senate report also reveals that CIA physicians inflicted rectal rehydration on at least five detainees, using it as a form of behaviour control and to force detainees to yield information.[11]

Limitations add to complicity

These and similar limitations on clinical care constitute a new dimension of complicity in torture. Medical care can be and is routinely limited for various reasons in ordinary settings. But the restrictions on care at the CIA detention facilities did not arise from physician or resource availability or legitimate medical considerations. Resources, such as staff and medications, were available; they were simply not provided and medications were intentionally given at incorrect times explicitly to support the goal of torture—that is, to "psychologically dislocate the detainee, maximize his feelings of vulnerability and helplessness, and reduce or eliminate his will to resist our efforts to obtain critical intelligence."[11]

Moreover, consent was dispensed with. Prisoners have a right to informed consent, although as in other circumstances, it can be over-ridden so long as procedural and substantive guidelines are followed. Evidence from the Senate Select Committee on Intelligence shows that consent was not part of clinical practice at the secret detention facilities. Ignoring prisoners' right to consent was instead part of the dehumanising process.

Dual loyalty—when a physician's professional obligations come into conflict with the needs of a third party such as an employer—exists in other settings, both military and civilian. Although the problems of dual loyalty in prison health are particularly challenging, at the secret detention facilities the guidelines ordered, and physicians appear to have demonstrated, loyalty only to the CIA. There is no evidence that either the agency or the medical staff gave more than lip service to the "highest professional and ethical standards" and "appropriate care."

Wider implications

The declassified guidelines show that healthcare professionals were directed to undermine their fundamental ethical obligations regarding clinical care. The guidelines applied only in CIA facilities, but analysis of them has global implications.

The World Medical Association's Declaration of Tokyo is a strong statement against medical participation in torture but needs to be more specific about clinical care in detention facilities. The declaration is clear that, "The physicians' fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose."[2] It emphasises "clinical independence" and confidentiality, mandating that physicians not engage in the use of professional skills to facilitate or enable torture. Alterations in standard clinical care made to further torture's aims should be explicitly included within this definition of torture.

Furthermore, the Declaration of Tokyo states that physicians must also not "countenance" or "condone" torture, meaning they have a duty to report it, speak out, and protect the detainee. We agree with the 2007 statement of the WMA General Assembly that "the absence of documenting and denouncing such acts might be considered as a form of tolerance and of non-assistance to the victims." The failure to document and denounce alterations of standard clinical care to facilitate torture therefore represents institutional complicity with torture. These principles warrant reaffirmation in the professional and public sphere, including as a fundamental part of medical education.[17-19]

Our findings suggest the need for another step. The WMA should amend the Declaration of Tokyo to provide that health professionals should not practise in an environment where torture is taking place except for the benefit of the detainee. There is precedent for such a provision. The American Psychological Association had been complicit with the Department of Defence in permitting psychologists to participate in interrogation and had declined to initiate disciplinary action against psychologists alleged to have engaged in torture.[20] In response, its members passed a referendum that psychologists should not work in detention settings where violations of international law or the US Constitution take place, unless they are working directly for the person detained or for a third party

seeking to protect their human rights. A similar approach could be incorporated into the Declaration of Tokyo.

Finally, professional associations of physicians, psychologists, psychiatrists, and other health professionals, as well as licensing authorities, should sanction health professionals who have participated in torture. Despite calls over the decade for punishment of physicians who participate in torture, cases of such punishment are rare.[17-22] When physicians have routinely violated their most basic commitment to patients' medical care, medical professional societies and licensing boards should impose disciplinary action, and as Miles and Freedman urge, the Declaration of Tokyo should make clear that such action should be possible indefinitely, so that the passage of time does not provide protection.[17]

If physicians and other health professionals refuse to be at torture sites in any capacity, and their professional associations and licensing boards punish collusion in torture as incompatible with professional practice, the abhorrent illegal and unethical practice of torture might be weakened. We need to remove the professional and institutional imprimatur that allows it to be carried out with impunity.

Key messages

- Routine care at secret interrogation sites run by the US Central Intelligence Agency was compromised to further the aims of torture
- Healthcare professionals participating in such compromised clinical care are complicit in torture
- Professional organisations should stipulate that members do not practise in an environment where torture is taking place unless they are working exclusively for the benefit of the patient
- Those who violate this obligation should be disciplined

Contributors and sources: ZB is an internist and bioethicist, expert in understanding clinicians' ethical obligations in the context of routine care. He is the guarantor of the article, and produced initial drafts and approaches. MDeC is an internist and bioethicist with these areas of expertise and additional expertise in global bioethics, human rights, and institutional ethics. He supervised the article. LSR is expert in public health and human rights, and in particular the content of the CIA medical guidelines and clinical professionals' complicity in torture.

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