



HEALTH  
PROFESSIONALS  
AND HUMAN  
RIGHTS

ENSURING RESPECT FOR THE  
RULE OF LAW IN DETENTION  
FACILITIES

## A World Justice Project Working Group Report

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# Health Professionals and Human Rights

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## Ensuring Respect for the Rule of Law in Detention Facilities

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## Forward from the Working Group

In July of 2008 over 500 global leaders came together in Vienna, Austria at the inaugural World Justice Forum. This forum was the outgrowth of an effort by the World Justice Project, a multinational multidisciplinary movement dedicated to bring together thought leaders from several fields to find ways to work together to strengthen the rule of law within and across countries. The work of this inaugural forum concluded with pledges from the participants that they would continue to work together in smaller workgroups, across disciplines, to foster efforts that fulfilled the goal of advancing the rule of law.

This report represents the work of one such multidisciplinary workgroup using as its basis recommendations from Physicians for Human Rights (PHR), a leading non-governmental organization with significant experience in the areas of prisoner health. PHR wrote a letter to then President-elect Obama in December of 2008, asking the Obama administration to take six key steps to help enhance the integrity of military medicine and psychology.<sup>1</sup> This report analyzes those six steps in accordance with international law and medical ethics and makes concrete recommendations to states who seek to improve their compliance with the rule of law in the area of detainee care.

All government officials and their agents, including health care professionals working for the state, are subject to the law. In addition, health care professionals, due to the nature of their profession, are guided by ethical canons and standards issued by professional associations.

The global security crisis has once again raised the issue of the proper role of health professionals in ensuring human rights abuses are not carried out in the furtherance of national security. In response, health professional associations have continued to reflect upon the ethical obligations of their members, issuing new statements and guidelines to help ensure that their members are not complicit in rule of law violations.

Although the work of these professional bodies should be commended, it is ultimately the responsibility of the state to ensure that its agents abide by the law. In the field of detainee health rights, states must ensure that the medical treatment of detainees respects human dignity, and does not amount to torture or cruel, inhuman or degrading treatment. States must also ensure that if such violations do

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<sup>1</sup> Physicians for Human Rights, Letter from John C. Bradshaw to President-elect Obama (December 5, 2008), available at: <http://physiciansforhumanrights.org/library/letter-2008-12-16.html> (last accessed April 22, 2009).

take place, formal processes are in place to review the actions of state agents. Perpetrators must be held accountable under the law. Victims must also be provided with an appropriate remedy. More specifically:

- States must recognize and manage the risk posed by dual loyalties. Detention policies, including the role of the clinician in the chain of command, and the decision making authority for medical treatment of detainees, should be reviewed and modified, where appropriate, to protect full clinical autonomy. Health professionals should be informed of their obligation to work in the best interest of their patients, and encouraged to exercise professional judgement.
- States should undertake a review of the involvement of health care professionals in interrogation, being mindful of the need to ensure compliance with international legal obligations. States should avoid putting health professionals into situations that will create ethical conflicts with their professional ethical codes. Existing policies should be harmonized with the recommendations and ethical codes of professional codes to the extent practicable.
- States must protect the rights of detainees. In developing hunger strike policies for detention facilities, states should review health professional association guidelines, and to the extent possible, design or modify policies in accordance with national and international medical ethics standards. During a hunger strike, states should consider inviting independent health professionals to monitor activities. Health professionals should be obligated to consult within their chain of command to obtain professional guidance when ethical dilemmas about the treatment of hunger strikers arise.
- States should review their policies concerning the administration of drugs to detainees in light of their obligations under international law. Involuntary drugging of detainees should only be used in circumstances that are consistent with the principles of medical ethics and national and international law.
- States should establish a mechanism for dialogue on a regular basis among state officials responsible for detainee operations, medical professional organizations and associations, and other leading medical ethicists. Institutionalizing a process for such an exchange will foster transparency, help prevent ethical conflicts, and help ensure that state health professionals do not commit ethical violations and have, at a minimum, access to the same ethical resources and tools as their civilian counterparts.

- States should conduct a prompt investigation into alleged detainee abuse, and ensure appropriate domestic legislation for the prosecution of offenders. To the extent that allegations of abuse are widespread, a public commission of inquiry may be warranted to make recommendations and to avoid future violations. When detainee abuse is substantiated, States must take appropriate action. Professional associations should also undertake investigations of their members and provide support for whistleblowers.

The members of the working group have presented this evaluation as a way to advance the discussion around professional obligations and in the spirit of advancing, in a positive way, the rule of law globally. These are not new ideas. But ones, in our humble opinion, all humanity needs to live by.

“ I will practice my profession with conscience and dignity...I will not use my medical knowledge contrary to the laws of humanity”

Declaration of Geneva (1948), Adopted by the General Assembly of the World Medical Association at Geneva Switzerland, September 1948.

## 1. Introduction

In July of 2008 at the World Justice Forum in Vienna, the World Justice Project (WJP) presented a new Rule of Law Index,<sup>2</sup> geared towards assessing countries' adherence to the rule of law. The central precept of the rule of law is the notion that states operate within a legal framework, and state conduct is governed by law.<sup>3</sup> The rule of law requires not only a robust network of fair and just laws at the international, national and local levels, but also a system for their fair and effective interpretation and implementation.

Declarations, resolutions, guidelines, professional association rules, non-binding agreements between states and like instruments, though not binding in international or domestic law, can help inform state practice<sup>4</sup>, including in matters of detention.<sup>5</sup> These instruments may be produced not only by states but also by international organizations, non-governmental organizations, and leading scholars.

To date, rule of law scholarship in this area has largely been set forth by judges, lawyers, and legal professional associations. There are, however, a host of other actors who work on the front lines of state action, and who may be able to identify opportunities to improve state compliance with the rule of law.

In addition to drawing on international law, this report focuses on codes of medical ethics developed by health professionals at the national and international levels,

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<sup>2</sup> World Justice Project, Rule of Law Index, *available at*: <http://www.worldjusticeproject.org/rule-of-law-index/> (last accessed April, 22, 2009). Note that the index is an evolving document. All citations to the index contained herein are to version 2.0.

<sup>3</sup> Thomas Carothers, *The Rule of Law Revival*, *Foreign Affairs*, 77 No. 2 (March/April 98) at 4.

<sup>4</sup> Dinah Shelton, COMMITMENT AND COMPLIANCE: THE ROLE OF NON BINDING NORMS IN THE INTERNATIONAL LEGAL SYSTEM 13 (Dinah Shelton, ed., 2000) [Commitment and Compliance].

<sup>5</sup> In addition to helping inform state practice, non-binding instruments can provide evidence on whether a rule has become international law. “A rule of international law is one that has been accepted as such by the international community of states (a) in the form of customary law; (b) by international agreement; or (c) by derivation from general principles common to the major legal systems of the world. RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE U.S. § 102 (1987)

particularly codes that address the context of the treatment of detainees (see Appendix A, Legal Instruments). These codes are often important to the overall rule of law, especially where they inform, uphold and enforce international human rights and humanitarian laws.

Health professionals have special expertise in the provision of health services, the promotion and analysis of human health standards, and the standards required of themselves as practitioners. Furthermore, health professions are defined by core principles such as healing, “do no harm”, and clinical autonomy. The professional organizations established by doctors, psychologists, nurses, and other health professionals have much to contribute in the development of rules that reflect their expertise and ensure high standards of ethics.

Health professionals are entrenched in daily detainee care and are often well-positioned to identify detainee abuse. However, dual loyalties, a lack of professional autonomy, isolation, and unclear ethical standards may all contribute to a lack of “professional conscience”<sup>6</sup> amongst some health professionals. This report makes recommendations for the purpose of enhancing the medical treatment of detainees and the professional and ethical framework available to state health care professionals involved in detainee operations. It uses, as a starting place, the recommendations made by Physicians for Human Rights outlining six steps to enhance the integrity of military medicine and psychology.<sup>7</sup> This report examines the international legal and ethical support for those recommendations.

Detention facilities raise numerous legal and ethical questions for health professionals and the state: how should health services be provided to detainees, who should have access to detainees' medical information, and who should make medical decisions? What forms of treatment or conditions of detention are incompatible with their role as health professionals? Who should be involved in planning, conducting and monitoring interrogations? If a detainee is on a hunger strike, should he or she be fed artificially, and if so, when and how? Can drugs ever be administered to a detainee against his or her wishes, and if so, when and how?

Translating the spirit and letter of international and domestic law into answers to these types of questions raised above is a delicate task, but health professionals' organizations and their ethical codes can provide valuable assistance. By turning to the codes of medical ethics already established by health professionals through their international and domestic organizations, and by working in partnership with these organizations, governments can promote a more thoughtful, effective and

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<sup>6</sup> British Medical Association, *THE MEDICAL PROFESSION AND HUMAN RIGHTS, HANDBOOK FOR A CHANGING AGENDA 5* (2001) [“BMA Handbook”].

<sup>7</sup> Physicians for Human Rights Letter, *supra* note 1.

inclusionary approach to the rule of law and ensure greater respect for human rights in practice.

With this in mind, this report calls on the United States and other governments to restore respect for both medical ethics and for the rule of law, and specifically to:

1. Restore clinical autonomy.
2. End the participation of health professionals in interrogation.
3. Reform the protocols for hunger strikes to respect patient autonomy.
4. Prohibit the involuntary administration of medications.
5. Establish an advisory body on medical ethics in detention settings.
6. Investigate and ensure accountability for medical misconduct.

The recommendations in this report are not specific to detention operations conducted in connection with armed conflict.<sup>8</sup> The recommendations contained herein, and the principles upon which they are based, are intended to help inform state practice in a variety of settings and situations, including protecting detainee health after release or transfer. The guiding principle behind both this report, and the Rule of Law Index that inspired it, is that states are bound by customary international law, and the international agreements to which they are party.<sup>9</sup> It is beyond the scope of this report to formally analyze which international instruments are binding on specific states.

## 2. Restoring Respect for Medical Ethics and the Rule of Law

### 1. Ensure Clinical Autonomy

Health professionals working in detention facilities face unique challenges. Nurses, doctors, psychiatrists and psychologists may be torn between their obligations to the patients they serve, to the broader detention facility population (particularly in the case of communicable disease), and to the state<sup>10</sup> During armed conflict,

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<sup>8</sup> In the context of armed conflict, the report will primarily focus on obligations arising under Common Article 3 of the *Geneva Conventions*. Common Article 3 is consistent across the four *Geneva Conventions*, and provides for the basic minimum humane treatment of all persons, including those in detention. *Geneva Convention Relative to the Treatment of Prisoners of War*, art. 3. August 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135.

<sup>9</sup> WJP, *Rule of Law Index*, *supra* note 2 at 5: The government is bound by international agreements to which it is a party and by customary international law.

<sup>10</sup> See the views expressed by one U.S. Counterintelligence Liaison Officer, cited by Jonathan H. Marks, *Doctors as Pawns? Law and Medical Ethics at Guantanamo Bay*. *Seton Hall L. Rev.* 37:711, 279 (2007) [*“Doctors as Pawns?”*] noting the pressures faced by military physicians to

“identification with the cause,” may also present complex ethical challenges to the health care professional.<sup>11</sup>

Health professionals must balance many obligations. The mere presence of, or access to, sufficient numbers of health professionals in a detention facility is not an independent safeguard of detainee health and well-being. As the British Medical Association has noted, if health professionals were complicit in rights violations it could bring “a mask of respectability to abusive procedures.”<sup>12</sup> During detention operations, the loyalties facing health professionals require the physician to balance the health interest of the individual patient, with the collective good of society at large.<sup>13</sup> One mechanism for achieving such balance is clinical autonomy.

Regardless of the particular context of detention, the dual obligations facing health professionals raise similar fundamental issues and create a need for institutional mechanisms to assist the physician in balancing the best interest of the individual patient (the therapeutic relationship), with the collective good of society at large (the physician’s social purpose).<sup>14</sup> One such mechanism is clinical autonomy.

Health professionals with insufficient clinical autonomy could conceivably prioritize the interest of the state over the individual patient. In detention settings, insufficient clinical autonomy may lead to failure to provide necessary treatment, or the provision of treatment not in the best interest of the patient. Without full clinical autonomy, health professionals could feel pressured to violate rules and protocols in a way that could constitute ethical violations. By continuing to provide clinicians with sufficient autonomy, we can help ensure that health professionals do not feel pressure to perform to standards which might compromise their ethics.

Training can also be effective in enabling health care professionals to exercise their autonomy and report suspected violations they observe. In the context of armed conflict, training in the Geneva Conventions is already required by an article common to all four Conventions. (First Convention, Article 47; Second Convention,

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support the military establishment: “Most of the PAs [physician assistants] or doctors that we use have been through medical school due to military scholarships. They owe the military big bucks. If they refused to aid us then they might be brought up on charges in an internal trial and would be forced to repay the military.”

<sup>11</sup> Duncan Forrest, James Barrett, *Commentary: ethical pitfalls can be hard to avoid*, BMJ 329, 399 (2004); *Doctors as Pawns?*, *supra* note 10 at 727. See also the UK Council for Psychotherapy, Statement on Torture, *available at*:

[http://www.psychotherapy.org.uk/statement\\_on\\_torture.html](http://www.psychotherapy.org.uk/statement_on_torture.html) (last visited April 14, 2009). The UKCP is an umbrella organization for Psychotherapists. Their statement on torture is not binding.

<sup>12</sup> BMA handbook, *supra* note 6 at 49.

<sup>13</sup> M. Gregg Bloche & Jonathan H. Marks, *When Doctors Go to War*, N Engl J Med 352:1, 4 (2005).

<sup>14</sup> *Id.*

Article 48; Third Convention, Article 127; and Fourth Convention, Article 144.) Training for health care professionals should go beyond this required training and cover all forms of detention circumstances. Appropriate training can reinforce the principle of clinical autonomy, provide examples of how to deal with conflicting obligations, and reinforce the obligation to report suspected violations of law or ethics. Training serves to institutionalize the principles and desired behaviors and would ensure everyone – commanders, interrogators, guards, and health care professionals – understand the role of health care professionals in detention and interrogation settings.

### Health professionals and the appropriate use of authority

The WJP’s Rule of Law Index recognizes the importance of a broad distribution of government powers. According to the authors of the Index:

Governmental checks take many forms; they do not operate solely in systems marked by a formal separation of powers, nor are they necessarily codified in law. What is essential is that authority be distributed whether by formal rules or by convention, in a manner that ensures that no single organ of government has the practical ability to exercise unchecked power.<sup>15</sup>

Health professionals are ideally suited in the detention context to ensure the appropriate use of government authority. Numerous health professional bodies have recognized that clinical autonomy is vital for the empowerment of health professionals. Clinical autonomy is also supported in international law. In armed conflict Additional Protocol I to the Geneva Conventions endorses both the autonomy of health professionals and the intersection of medical ethics and international law. In addition to recognizing the general right of health professionals to provide medical care without sanction,<sup>16</sup> the Protocol permits health professionals to refuse to act where such actions would violate international law or medical ethics:

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<sup>15</sup> Mark David Agrast et al., *The World Justice Project Rule of Law Index: Measuring Adherence to the Rule of Law around the World*, 8 (2008); Rule of Law Index, *supra* note 2 at 2: the powers of the government and its officials and agents are limited by governmental and nongovernmental checks.

<sup>16</sup> *Protocol Additional to the Geneva Conventions of 12 August 1949 (Protocol I) 1977*, Article 16 (1); The Commentary on Article 16 of Protocol I also makes it clear that: “There could be no question [during the drafting of these provisions] of interfering with the application of national legislation”. International Committee of the Red Cross, *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949* 656 (1987). Many, but not all, of the Protocol I’s provisions are viewed as embodying customary international law; however, although the great majority of states are parties to Protocol I, the Protocol has been the subject of many declarations and reservations. A number of its provisions are controversial, including a provision concerning to which conflicts it may apply. The United States has not ratified either

Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules.<sup>17</sup>

The above noted provision is of particular interest as it directs the health professional to the ethical rules (such as those established by professional health bodies) to inform the content of permissible conduct under international law. The commentary to Protocol 1 supports this view, noting of the “medical rules” that although

[T]hese rules have not been adopted by States and have no binding force in international law. Nevertheless, they constitute a valuable instrument of reference and no one contests the principles on which they are laid down.”<sup>18</sup>

National guidelines reflected in health care providers’ credentialing boards and ethical guidelines of professional organizations provide that physicians must maintain complete clinical autonomy in their practice.

#### Medical ethics support clinical autonomy in all settings

The World Medical Association (“WMA”), an international organization representing physicians and comprised of over 80 national medical associations, held in its 1975 Declaration of Tokyo that:

A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor’s fundamental role is to alleviate the distress of his or her fellow man, and no motive, whether personal, collective or political shall prevail against this higher purpose.<sup>19</sup>

This provision echoes the World Medical Association’s International Code of Medical Ethics which calls upon the physician to “always exercise his/her independent professional judgment, ”<sup>20</sup> and “... in all types of medical practice, be dedicated to

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Protocol.

<sup>17</sup> *Protocol 1, id.*, Article 16 (1)(2).

<sup>18</sup> International Committee of the Red Cross, *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949* 656, *supra* note 16.

<sup>19</sup> World Medical Association, *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*, adopted in Tokyo on October 1975, amended in Divonne-les-Bains (France) (May 2005 and May 2006) [“WMA Tokyo Declaration”] at ¶ 4.

<sup>20</sup> World Medical Association, *International Code of Medical Ethics*, adopted in London in

providing competent medical services in full technical and moral independence...”<sup>21</sup> Where the physician is acting for a third party, the physician must provide full disclosure.<sup>22</sup>

Most recently, the World Medical Association expanded its views on clinical autonomy in the Declaration of Seoul on Professional Autonomy and Clinical Independence.<sup>23</sup> This Declaration specifically recognized clinical autonomy and independence as an “essential principle of medical professionalism.”<sup>24</sup> The Declaration also described the central element of these principles as being “the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals.”<sup>25</sup>

In the case of armed conflict, the World Medical Association’s Regulations in Times of Armed Conflict provides specific instruction pertaining to the problem of dual loyalties: “If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients.”<sup>26</sup> The Regulations also state that “Physicians have a clear duty to care for the sick and injured. Provision of such care should not be impeded or regarded as any kind of offence. Physicians must never be prosecuted or punished for complying with any of their ethical obligations.”<sup>27</sup> For clarity, the Regulations further specify that physicians working in armed conflict situations must be granted “complete professional independence.”<sup>28</sup>

States must continue to ensure adequate clinical autonomy at the legislative and policy level, and in practice. An example of a situation which may implicate clinical autonomy can be found in the treatment of hunger strikers, discussed below. There is no doubt that hunger strikes raise difficult ethical dilemmas in detention settings. Even where clinical autonomy is preserved, physicians may still have difficulty balancing their obligation to respect the autonomy of the patient, and their obligation to preserve life.<sup>29</sup> Individual physicians will differ on where that balance

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October 1949, amended in Sydney (Australia) (August 1968), in Venice (October 1983), and in Pilanesberg (South Africa) (October 2006) [“WMA *International Code of Medical Ethics*”].

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> World Medical Association, *Declaration of Seoul on Professional Autonomy and Clinical Independence* (Korea) (October 2008).

<sup>24</sup> *Id.* at Art. 5.

<sup>25</sup> *Id.* at Art. 1.

<sup>26</sup> World Medical Association, *Regulations in Times of Armed Conflict*, adopted in Havana in October 1956, amended in Istanbul (October 1957), in Venice (October 1983), in Tokyo (2004), and in Divonne-les-Bains (France) (May 2006) at 1.

<sup>27</sup> *Id.* at 8.

<sup>28</sup> *Id.* at 12.

<sup>29</sup> Crosby et al. *Hunger Strikes, Force-feeding, and Physician’s Responsibilities*, JAM. 2007. 298(5) 563 at 565.

lies. Similarly, where a patient chooses to harm himself (suicide) or others (contagious diseases) by refusing treatment, the state may be obliged to restrict that choice. In these cases, patient choice may be negated by a legitimate exercise of government power. Where agreement cannot be reached within the facility, there should be a mechanism to appropriately examine those choices and interests to ensure they are legitimate in the particular case. The issue should be raised for decision by senior officials at the policy levels of government.

Careful thought must go into designing a system that ensures health professionals can exercise independent professional judgement and that health professional have the resources at hand to decide what is the most appropriate course of treatment. Final decision making, however, should always rest with the treating physician, consistent with his obligations to evaluate the mental and physical condition of the hunger striker.

Recommendation:

States must recognize and manage the risk posed by dual loyalties. Detention policies, including the role of the clinician in the chain of command and the decision making authority for medical treatment of detainees, should be reviewed and modified, where appropriate, to protect full clinical autonomy. Health professionals should be reminded of their obligation to act in the best interest of their patients, and encouraged to exercise independent professional judgement.

## 2. End the participation of health professionals in interrogation

Respect for the individual rights of accused and detained persons and the protection of everyone from unjust treatment or punishment are fundamental components of the rule of law.<sup>30</sup> Health professionals who participate in torture or other cruel, inhuman or degrading treatment or punishment not only violate the law, but also violate codes of medical ethics. Because of the concerns arising from the conduct of interrogations, many medical ethical codes have recently been amended to preclude health professionals from taking any role in interrogations. These further

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<sup>30</sup> WJP, Rule of Law Index, supra note 2 at 8: The laws protect the security of the person; 8.1: The laws protect persons from unjust treatment or punishment by the government, including torture, arbitrary arrest, detention and exile; 7: The laws are fair and protect fundamental rights; 7.5: The laws protect the rights of the accused and prohibit the retroactive application of criminal laws.

obligations arise as a result of health professionals' unique role as healers with special expertise.

### International Law and Torture

Torture and other cruel, inhuman or degrading treatment or punishment is prohibited in international law.<sup>31</sup> Anyone – including health professionals –involved in the commission of torture or cruel, inhuman or degrading treatment against any person, anywhere, should be investigated and prosecuted (see also Recommendation 6: Investigate and ensure accountability for medical misconduct).

Under international law, the prohibition on torture is *jus cogens* or a peremptory norm, binding on all states without derogation.<sup>32</sup> These prohibitions are also reinforced in numerous international treaties addressing human rights law and the law of armed conflict.<sup>33</sup>

In human rights law, the 1967 International Covenant on Civil and Political Rights (ICCPR) provides in Article 7 that “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be

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<sup>31</sup> Although this report focuses on international law, most states also have domestic laws that prohibit torture and mistreatment.

<sup>32</sup> See e.g. UN Committee Against Torture, *General Comment No. 2*, UN Doc.CAT/C/GC/2 (24 January 2008) at ¶ 1; UN Human Rights Committee, *General Comment No. 24*, UN Doc. CCPR/C/21/Rev.1/Add.6, 52<sup>nd</sup> sess. (1994) at ¶ 10; Manfred Nowak and Elizabeth McArthur, *THE UNITED NATIONS CONVENTION AGAINST TORTURE: A COMMENTARY* at 28 and 118 (2008) (both torture and other cruel, inhuman or degrading treatment or punishment are prohibited by *jus cogens*); Manfred Nowak, *THE UN COVENANT ON CIVIL AND POLITICAL RIGHTS: CCPR COMMENTARY* at 157-8 (2<sup>nd</sup> ed. 2005) (both torture and other cruel, inhuman or degrading treatment or punishment are prohibited by *jus cogens*); American Law Institute, *Restatement (Third) of the Foreign Relations Law of the U.S.*, §702 (1987) at comment (n) (both torture and cruel, inhuman or degrading treatment and punishment are prohibited by *jus cogens*); *Prosecutor v. Furundzija*, IT-95-171/1-T, (10 December 1998) (International Criminal Tribunal for the Former Yugoslavia, Trial Chamber); *Barcelona Traction, Light and Power Company, Limited*, Second Phase, Judgment, [1970] I.C.J. Rep. 32 at ¶ 33 (recognized the “basic rights of the human person” in a brief list of *jus cogens* norms); etc.

<sup>33</sup> There is disagreement in the international community over whether international human rights obligations apply during armed conflict. Some states take the position that the law of armed conflict is *lex specialis*. See e.g. Michael J. Dennis, ICJ Advisory Opinion on Construction of a Wall in the Occupied Palestinian Territory: Application of Human Rights Treaties Extraterritorially in Times of Armed Conflict and Military Occupation, 99 Am. J. Int’L. 119 (2005)., see also Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion, [1996] I.C.J. Rep. 226 at ¶ 25; Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territories, Advisory Opinion, [2004] I.C.J. Rep. at para 106; UN Committee Against Torture, Conclusions and Recommendations of the Committee Against Torture: United States of America, 36<sup>th</sup> sess., UN Doc. CAT/C/USA/CO/2 (2006) at ¶14.

subjected without his free consent to medical or scientific experimentation.”<sup>34</sup> The 1984 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT or Convention Against Torture) requires all Parties to the CAT to ensure that acts of torture, including attempts and complicity, are offenses under domestic criminal law. It also requires its members to take measures necessary to establish jurisdiction over offenses committed within its territory and over nationals of the State.<sup>35</sup>

Common Article 3 of the 1949 Geneva Conventions requires that persons who are not taking an active part in hostilities, including persons who are in detention, “shall in all circumstances be treated humanely”. The subsections of Common Article 3 specify that “violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture” and “outrages upon personal dignity, in particular humiliating and degrading treatment”, among other things, “remain prohibited at any time and in any place whatsoever”. It also requires the provision of medical care for the wounded and sick.<sup>36</sup>

The prohibition on states against committing torture or cruel, inhuman, or degrading treatment is non-derogable. There can be no justification for a state to engage in torture or cruel, inhuman, and degrading treatment in violation of applicable international human rights law or the law of armed conflict.<sup>37</sup>

Codes of medical ethics recognize these fundamental laws against torture or cruel, inhuman, or degrading treatment. Generally, these codes prohibit health professionals from involvement in such actions and call on them to assist in the prevention, reporting, and investigation of any abuses.

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<sup>34</sup> *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171 (entered into force 23 March 1976) [ICCPR]. .

<sup>35</sup> *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, 1465 U.N.T.S. 85 (entered into force 26 June 1987) [CAT or *Convention Against Torture*].

<sup>36</sup> Common Article 3 is found in all four *Geneva Conventions*. In the circumstances discussed in this report, the Third and Fourth Conventions are most relevant, which are: *Geneva Convention Relative to the Treatment of Prisoners of War*, 12 August 1949, 75 U.N.T.S. 135 (entered into force 21 October 1950) [Third Convention]; *Geneva Convention Relative to the Protection of Civilian Persons in Time of War*, 12 August 1949, 75 U.N.T.S. 287 (entered into force 21 October 1950) [Fourth Convention].

<sup>37</sup> See e.g. ICCPR, *supra* note 34 at Art. 7 “no one”; UN Human Rights Committee, *General Comment No. 7*, 16<sup>th</sup> sess. (30 May 1982); UN Human Rights Committee, *General Comment No. 20*, 44<sup>th</sup> sess. (10 March 1992); *Convention Against Torture*, *supra* note 35 at Art.2(2); UN Committee Against Torture, *General Comment No. 2*, *supra* note 32 at ¶ 1-7; Nowak and McArthur, *supra* note 32 at 89; Nowak at 157, 183-184, and generally in that chapter.

## Medical Ethics and abusive treatment of detainees

The UN General Assembly's 1982 Principles of Medical Ethics states that it “is a gross contravention of medical ethics, as well as an offense under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.”<sup>38</sup> Principle 4 further states that “it is a contravention of medical ethics for health personnel to...apply their knowledge and skills in order to assist in the interrogation of ...detainees in a manner that may adversely affect the physical or mental health or condition of such... detainees and which is not in accordance with the relevant international instruments.” It also prohibits health professionals from certifying or participation in the certification of “prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.”<sup>39</sup>

The World Medical Association's 1975 Declaration of Tokyo holds that physicians shall not “countenance, condone or participate in”<sup>40</sup> or “provide any premises, instruments, substances or knowledge to facilitate”<sup>41</sup> torture or cruel, inhuman or degrading treatment.” The declaration suggests that physicians shall “not be present” if such practices are used or threatened,<sup>42</sup> and, in the case of armed conflict, shall report any breaches of the Geneva Conventions.<sup>43</sup> The World Medical Association's International Code of Medical Ethics instructs physicians to “not use [their] medical knowledge to violate human rights and civil liberties, even under threat”.<sup>44</sup>

The World Psychiatric Association, representing 100 national psychiatric associations, provided guidelines in its Madrid Declaration that “[p]sychiatrists

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<sup>38</sup> United Nations General Assembly, *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, GA Res. 37/194, UN Doc. A/RES/37/194 (18 December 1982) at Principle 2.

<sup>39</sup> *Id.* at Principle 4.

<sup>40</sup> WMA, *Tokyo Declaration*, *supra* note 19 at ¶ 1.

<sup>41</sup> *Id.* at ¶ 2.

<sup>42</sup> *Id.* at ¶ 4.

<sup>43</sup> *Id.* at ¶ 3.

<sup>44</sup> WMA, *International Code of Medical Ethics*, *supra* note 20.

shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.”<sup>45</sup>

The International Council of Nurses, a federation of national nurses' associations from 128 countries, adopted a position that, “[i]n caring for detainees...nurses are expected to adhere to ethical principles and...abstain from using their nursing knowledge and skills in any manner which violates the rights of detainees and prisoners”.<sup>46</sup> The International Council of Nurses position statement on torture, death penalty and participation in executions, “strongly affirms that nurses should play no voluntary role in any deliberate infliction of physical or mental suffering” and calls on nurses to “actively oppose torture” and to “speak up against and oppose any deliberate infliction of pain and suffering”.<sup>47</sup>

Many local professional associations, regulating bodies and government policies give similar directions prohibiting health professionals, and others, from involvement with torture or mistreatment in any way.

### Health professionals and special obligations precluding participation in interrogations

In addition to the international law prohibiting torture and cruel, inhuman or degrading treatment, health professionals have further duties that arise because of their role as healers. Many professional associations have concluded that health professionals are ethically precluded from participating in any security-related interrogations.

This viewpoint derives from health professionals' role and reputation as healers. Health professionals have a duty to refrain from causing harm. They must maintain clinical autonomy to perform their role with integrity.

Principle 3 of the UN General Assembly's Principles of Medical Ethics states:

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or

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<sup>45</sup> World Psychiatric Association, *Madrid Declaration on Ethical Standards for Psychiatric Practice*, adopted in Madrid on 25 August 1996, amended in Hamburg (8 August 1999), in Yokohama (26 August 2002), and in Cairo (12 September 2005), at item 2 of Guidelines Concerning Specific Situations, “Torture”.

<sup>46</sup> International Council of Nurses, *Nurses' Role in the Care of Detainees and Prisoners*, adopted in 1998, amended (2006), replacing previous policy adopted in 1975.

<sup>47</sup> International Council of Nurses, *Position Statement: Torture, Death Penalty and Participation by Nurses in Executions*, adopted in 1998, amended (2003 and 2006), replacing two prior policies adopted in 1989.

detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.<sup>48</sup>

This non-binding principle would preclude health care professionals from assisting states in the conduct of security related interrogations. The Principles of Medical Ethics emphasize that the only appropriate relationship for health personnel vis a vis detainees is to evaluate, protect, or improve their physical and mental health.<sup>49</sup>

Professional associations, as guardians of their own profession and its reputation, have further emphasized and defined the significance of this principle. The World Medical Association's Declaration of Tokyo states: "The physician's 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."<sup>50</sup>

The World Medical Association's Regulations in Times of Armed Conflict of the World Medical Association states that physicians' "primary obligation is to their patients" and that the "privileges and facilities afforded to physicians and other health care professionals in times of armed conflict must never be used for other than health care purposes".<sup>51</sup> Paragraph 2 deems the following conduct unethical:

- a. Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable for the patient's health care.
- b. Weaken the physical or mental strength of a human being without therapeutic justification.
- c. Employ scientific knowledge to imperil health or destroy life.
- d. Employ personal health information to facilitate interrogation.
- e. Condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.<sup>52</sup>

Similar policies have been advanced by other health profession associations. The International Council of Nurses states, with respect to prisoners and detainees, that "[n]urses' primary responsibility is to those people who require nursing care" and further provides that "[n]urses employed in prison health services do not assume

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<sup>48</sup> *Principles of Medical Ethics*, *supra* note 38 at Principle 3.

<sup>49</sup> Some have argued that the presence of health professionals during an interrogation can help protect the physical and mental health of detainees as it can lessen the likelihood of detainee abuse. For example, health professionals may be more sensitive to spotting interrogator "behavioural drift" and intervene before harm takes place. Stephen Behnke, *Ethics and interrogations: Comparing and contrasting the American Psychological, American Medical and American Psychiatric Association Positions*, and improve reporting of abuse. *Monitor on Psychology* (2006);37(7), 67.

<sup>50</sup> WMA, *Tokyo Declaration*, *supra* note 19 at 5.

<sup>51</sup> WMA, *Regulations in Times of Armed Conflict*, *supra* note 26 at 1 and 7.

<sup>52</sup> *Id.* at 2.

functions of prison security personnel, such as body searches for the purpose of prison security”.<sup>53</sup>

The World Psychiatric Association's Declaration of Hawaii provides that a psychiatrist “must never use his professional possibilities to violate the dignity or human rights of any individual or group” and “must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established”.<sup>54</sup>

In his writing on the situation of detainees at Guantánamo Bay, Paul Hunt, Special Rapporteur on the Right to Health, suggested that the involvement of any health professional in interrogations that have the possibility of adversely affecting a person's physical or mental health is unacceptable:

[T]he United Nations Principles and other codes of ethics for health professionals make no distinctions based on the role of the health professional. Their premise is that the knowledge and skills of health professionals should not be used to the detriment of humans; the particular position the professional holds therefore is not relevant. To the extent that health professionals “apply their knowledge and skills” to assist in any manner with interrogations that “may adversely affect” (emphasis added) the physical or mental health of the detainee, they violate professional ethics and the right to health of detainees.<sup>55</sup>

In the U.S. context, the ethical codes of several national associations of health professionals prohibit their members from participating in interrogations.

The American Medical Association's 2006 addition to its Code of Medical Ethics, titled Physician Participation in Interrogation, opined that “[p]hysicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician’s role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.”<sup>56</sup> Monitoring an interrogation constitutes participation.<sup>57</sup> The Code does permit, however, physician assistance in the development of and training for interrogation

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<sup>53</sup> ICN, *Nurses' Role in the Care of Detainees and Prisoners*, *supra* note 46.

<sup>54</sup> World Psychiatric Association, *Declaration of Hawaii / II*, adopted in Vienna on 10 July 1983 at 7.

<sup>55</sup> UN Economic and Social Council, *Situation of Detainees at Guantanamo Bay*, 62<sup>nd</sup> sess., UN Doc. E/CN.4/2006/120 (2006) (“Situation of Detainees at Guantanamo Bay”) at 78 (per Paul Hunt).

<sup>56</sup> American Medical Association, *Code of Medical Ethics, Opinion 2.068, Physician Participation in Interrogation*, issued November 2006 based on the report “Physician Participation in Interrogation,” adopted June 2006, at 2.

<sup>57</sup> *Id.* at 3.

strategies, provided these do not “threaten or cause physical injury or mental suffering” and are “humane and respect the rights of individuals”.<sup>58</sup>

The American Psychiatric Association's 2006 Psychiatric Participation in Interrogation of Detainees: Position Statement reflects a similar standard. It provides that “[n]o psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere,” including “being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques”. It specifies further that “[p]sychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients, including advocating for their patients, and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military or civilian agencies or law enforcement authorities.”<sup>59</sup> Psychiatrist must also “disclose any part of the medical records of any patient, or information derived from the treatment relationship, to persons conducting interrogation of the detainee”.<sup>60</sup> However psychiatrists may provide general training to personnel involved in interrogation on topics such as recognizing and responding to mental illness and the possible medical effects of techniques and conditions.<sup>61</sup>

The involvement of psychologists in interrogation has also been considered at length by the American Psychologists Association. Following strong opposition to a 2006 resolution of the American Psychologists Association that allowed for continuing participation in interrogation,<sup>62</sup> the Association passed a new resolution pursuant to a member petition process. The approval of the resolution represents a significant change in the American Psychological Association policy regarding the involvement of psychologists in interrogations. The September 2008 resolution, which will take effect in August 2009, provides that “psychologists may not work in settings where persons are held outside of, or in violation of, either International Law (e.g., the UN Convention Against Torture and the Geneva Conventions) or the United States Constitution (where appropriate), unless they are working directly for the persons being detained or for an independent third party working to protect human rights.”<sup>63</sup>

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<sup>58</sup> *Id.* at 4.

<sup>59</sup> American Psychiatric Association, *Psychiatric Participation in Interrogation of Detainees: Position Statement*, approved May 2006 by Board of Trustees and the Assembly of District Branches at 2(b).

<sup>60</sup> *Id.* at 2(c).

<sup>61</sup> *Id.* at 3.

<sup>62</sup> American Psychologists Association, *Resolution Against Torture and Other Cruel, Inhuman, and Degrading Treatment or Punishment*, adopted by APA Council of Representatives on 9 August 2006.

<sup>63</sup> American Psychologists Association, *Petition Resolution*, passed on 17 September 2008. A

Recommendation:

States should undertake a review of the involvement of health care professionals in interrogation, being mindful of the need to ensure compliance with international legal obligations. States should avoid putting health professionals into situations that will create ethical conflicts with their professional ethical codes. Existing policies should be harmonized with the recommendations and ethical codes of professional health associations to the extent practicable.

### 3. Reform the protocols for hunger strikes to respect patient autonomy

While national and international law requires respect for certain individual rights of detained persons, observation of these norms in specific circumstances, such as hunger strikes, raise complex issues of personal autonomy, capacity to consent, and preservation of life, and can result in uncertainties as to the most appropriate state conduct. To this end, non-binding agreements, guidelines, rules and like instruments developed by states, international and non-governmental organizations, and professional associations can assist the state in interpreting and applying norms within a particular context.

Medical treatment of persons participating in a hunger strike is a medical issue and health professional organizations have particular expertise to provide guidance. Recommendations from health professional bodies regarding the ethical treatment of hunger strikers are useful tools for the state in determining best practices. Such recommendations are not binding on either the physician or the state and do not create or interpret law. Force feeding raises significant issues of medical ethics and can create a conflict of values for physicians.<sup>64</sup> Under the circumstances, the treatment of hunger strikers raises issues that any state should consider closely.<sup>65</sup>

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footnote to the resolution states “It is understood that military clinical psychologists would still be available to provide treatment for military personnel.”

<sup>64</sup> *Tokyo Declaration* Preamble, “Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians.” The Declaration also acknowledged in paragraph 15 that some physicians may not be able to abide by a hunger striker’s refusal of treatment or artificial feeding (and should refer the patient to another physician).

<sup>65</sup> *Situation of Detainees*, *supra* note 55 at ¶ 54 (per Manfred Nowak the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) and the recommendation at ¶ 88.

## Consent and Medical Treatment

Several medical ethics statements currently hold that medical treatment should not be forced in many circumstances. These statements strongly recommend appropriate, informed consent of medical procedures. Force feeding a person on a hunger strike who has the mental capacity to make autonomous decisions may create an ethical dilemma for a physician trying to balance the principle of beneficence and respect for individual autonomy.

The World Medical Association's 1975 Declaration of Tokyo emphasizes that the key question in dealing with persons participating in hunger strikes is capacity for consent. The decision of a detainee with capacity to give or refuse consent should be respected:

6. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially.

The Declaration of Tokyo has been specifically adopted by the American Medical Association, among other groups, and reflects the broad consensus that force-feeding a competent patient capable of unimpaired and rational judgment is unethical.<sup>66</sup>

In 1991, the World Medical Association expanded on the Declaration of Tokyo by issuing the Declaration of Malta, ("Declaration on Hunger Strikers"). This Declaration provides more comprehensive guidance on the ethical standards and procedures during a hunger strike.<sup>67</sup> The emphasis is on voluntary and informed consent, ascertainment of true intentions, and respect for patient autonomy:

3. Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

The Declaration of Malta sets general standards on how to assess voluntariness and capacity, maintain trust and confidentiality, and provide care in the context of a hunger strike. It clarifies that artificial feeding is ethically appropriate in some

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<sup>66</sup> American Medical Association, *Policy H-65.997 Human Rights* ("AMA endorses World Medical Association's Declaration of Tokyo").

<sup>67</sup> World Medical Association, *Declaration on Hunger Strikers*, adopted in Malta in November 1991, amended in Marbella (Spain) (September 1992) and Pilanesberg (South Africa) (October 2006) ["*Malta Declaration*"].

circumstances: including when the patient gives explicit or implied consent to feeding, if an incompetent patient provides no independent pre-expressed wishes refusing artificial feeding, if the patient is determined to be mentally impaired, or if the refusal is thought to be made under duress.<sup>68</sup> The Declaration of Malta also clarifies the World Medical Association's consensus that feeding accompanied by threats, coercion, force, or use of physical restraints can constitute inhuman and degrading treatment in certain circumstances:

21. Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

Even while stating that forced treatment is unethical in some circumstances, however, the Declaration of Malta explicitly recognizes that some physicians, as a matter of conscience, may be unable to abide by a hunger striker's refusal of treatment.<sup>69</sup> Such recognition that not all physicians may concur with or be able to practice this ethical guideline underscores the complexity of the ethical decisions involved. Further, the Declaration also acknowledges the additional difficulties encountered in collective hunger strikes and hunger strikes in custodial settings.<sup>70</sup>

Paul Hunt, the UN Special Rapporteur on the Right to Health, discussed forced feeding in the detention context, emphasizing the importance of patient autonomy and the right to refuse treatment. Mr. Hunt opined that "the force-feeding of competent detainees violates the right to health as well as the ethical duties of any health professionals who may be involved".<sup>71</sup>

Concerns about the forced feeding of hunger strikers in detention facilities have also been raised by the Special Rapporteur on Torture<sup>72</sup> and individual physicians.<sup>73</sup> Protocols used in detention facilities should reflect applicable national and international law and, to the extent possible, be informed by ethical guidelines developed by health professional associations.

#### Recommendation:

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<sup>68</sup> *Id.* at ¶ 20.

<sup>69</sup> *Id.* at ¶ 15.

<sup>70</sup> *Id.* at ¶ 1.

<sup>71</sup> *Situation of Detainees at Guantanamo Bay*, *supra* note 55 at the recommendation at ¶ 94. See also ¶¶ 79-82 (per Paul Hunt) and the recommendation at ¶ 103.

<sup>72</sup> *Id.* ¶ 54 (per Manfred Nowak).

<sup>73</sup> David J Nicholl, Holly G Atkinson, John Kalk, William Hopkins, Elwyn Elias, Adnan Siddiqui, Ronald E Cranford, Oliver Sacks and on behalf of 255 other doctors, "Forcefeeding and restraint of Guantanamo Bay hunger strikers" 367: 9513 *The Lancet* 811 (2006). Nicholl et al., *supra* note **Error! Bookmark not defined.**

States must protect the rights of detainees. In developing hunger strike policies for detention facilities, States should review health professional association guidelines, and to the extent possible, design or modify policies in accordance with national and international medical ethics standards. During a hunger strike, States should consider inviting independent health professionals to monitor activities.

#### 4. Prohibit involuntary administration of medication outside of the therapeutic or diagnostic framework

As with artificial feeding, the administration of drugs to detainees is a question of medical treatment and raises significant legal concerns, including the obligation of the state to protect certain rights of detainees.<sup>74</sup> Health professional organizations have expertise on the appropriate rules and procedures that can help ensure respect for patient's rights, uphold the ethical duties of health professionals, and comply with international laws. The rule of law not only requires respect for fundamental rights, it also urges respect for the voice of health professionals and guidelines respecting fundamental rights.

##### Treatment without consent may violate the right to health and medical ethics

Medical standards generally require the consent of the patient before the administration of drugs. If the patient does not have the mental capacity to make such decisions, the consent of a person acting on the patient's pre-expressed wishes. The UN Principles on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care<sup>75</sup> hold that medications "shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others."<sup>76</sup>

The involuntary administration of medication, outside of the therapeutic or diagnostic framework and without free, informed consent may be a breach of

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<sup>74</sup> WJP, *Rule of Law Index*, *supra* note 2 at 7.5: the laws protect the rights of the accused and prohibit the retroactive application of criminal laws; 8.1, the laws protect persons from unjust treatment or punishment by the government, including torture, arbitrary arrest, detention and exile; 8.2: the laws protect against and punish crimes against the person. See also Article 3, of the *Universal Declaration of Human Rights*, G.A. Res. 217A (III) U.N. Doc. A/810 at 71 (1948).

<sup>75</sup> *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, G.A. Res. 46/119, U.N. GAOR, 46<sup>th</sup> Sess., Supp. No. 49, at 189, U.N. Doc. A/46/49 (1991).

<sup>76</sup> *Id.* at Principle 10(1).

medical ethics and an assault against the victim's physical and mental integrity. In some extreme circumstances, it could rise to the level of torture or other cruel, inhuman or degrading treatment or punishment.

The comments of Special Rapporteur Paul Hunt on the right to health and the issue of consent to treatment, although directed to the context of forced feeding, are equally relevant to other situations of forced medical treatment including involuntary drugging:

From the perspective of the right to health, informed consent to medical treatment is essential, as is its “logical corollary” the right to refuse treatment. A competent detainee, no less than any other individual, has the right to refuse treatment. In summary, treating a competent detainee without his or her consent ... is a violation of the right to health, as well as [of] international ethics for health professionals.<sup>77</sup>

#### Administration of medication for the purpose of restraint, punishment or coercion may violate international medical ethics

The involuntary drugging of detainees to punish or for the improper treatment of actual medical conditions may violate codes of medical ethics. In addition, the UN's Principles of Medical Ethics provides that health professionals may not restrain detainees by any means unless it is necessary to do so as per “purely medical criteria” for certain limited purposes and only if the restraint presents no hazard to the detainee's health.<sup>78</sup> The use of involuntary drugging for certain other purposes (for example, as a method of interrogation, punishment, or to induce stress in the detainee, or cause harm to mental and physical health) would be a serious contravention of the ethical standards applicable to health professionals. Such actions violate health professionals' duty to promote health and avoid harm as well as their obligation of primary loyalty to the patient and not to third parties.

Any injections not given in standard dosages for the treatment of recognized medical conditions could be considered experimental and may raise issues under the Nuremberg Code<sup>79</sup> and the Declaration of Helsinki<sup>80</sup> if given for purposes outside the

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<sup>77</sup> *Situation of Detainees at Guantanamo Bay*, *supra* note 55 at ¶ 82.

<sup>78</sup> *Principles of Medical Ethics*, *supra* note 38 at Principle 5. Principle 5 specifically states that procedures for the restraint of prisoners can only be carried out “for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.”

<sup>79</sup> “Nuremberg Code: Directives for Human Experimentation” in TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW NO. 10, VOL. 2. (Washington, D.C.: U.S. Government Printing Office, 1949) 181-182, reprinted by the U.S. National Institutes of Health.

<sup>80</sup> World Medical Association, *Ethical Principles for Medical Research Involving Human*

therapeutic or diagnostic framework. As an example, in situations of detention where the ICCPR applies, the UN Human Rights Committee has held that psychiatric experiments and forced injections of drugs against a detainee may constitute inhuman and degrading treatment in breach of Arts. 7 and 10 of the ICCPR.<sup>81</sup>

UN General Assembly Resolution 43/173 adopted the principle that that prisoners and detainees shall not be subjected to medical experimentation which could be detrimental to their health, even with their consent, thus reflecting sensitivity to the overall coercive context of detention.<sup>82</sup> In the context of non-international armed conflict, Common Article 3 of the Geneva Conventions prohibits “violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture.”

Medical professionals are ethically bound to respect the requirements of consent and capacity, beneficence and other ethical standards of medical practice. Health professionals are well placed to develop rules that respect their own medical standards while following international law.

Recommendation:

States should review their policies concerning the administration of drugs to detainees in light of their obligations under international law. Involuntary drugging of detainees should only be used in circumstances that are consistent with the principles of medical ethics and national and international law.

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*Subjects*, adopted in Helsinki, in June 1964, amended in Tokyo (October 1975), Venice (October 1983), Hong Kong (September 1989), Somerset West (South Africa) (October 1996), Edinburgh (October 2000), Washington (2002), Tokyo (2004), Seoul (October 2008) [*Declaration of Helsinki*"]. On the question of injections for non-medical purposes being experimental, see also the comments of Scott Allen, a physician and co-director of the Center for Prisoner Health and Human Rights (U.S.A.), with respect to drugging at Guantanamo Bay: Joby Warrick, “Detainees Alleged Being Drugged, Questioned: U.S. Denies Using Injections for Coercion” *Washington Post* 22 April 2008 at A01.

<sup>81</sup> *Viana Acosta v. Uruguay*, UN HRC No. 110/1981 and related discussion in Nowak, *supra* note 32 at 190-192.

<sup>82</sup> *Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment*, G.A. Res 43/173, 43<sup>rd</sup> Sess. U.N. GAOR Supp. No. 49, UN Doc A/43/49 (1988) at Principle 22.

## 5. Establish an advisory body on medical ethics in detention settings

One of the basic principles of the rule of law is that all persons, including the government and its officials are accountable under the law.<sup>83</sup> One of the key ways to ensure accountability is to establish appropriate internal and external controls and oversight mechanisms. Health professional associations can serve as a useful advisory mechanism. Establishing a formal medical advisory body, which would include members of leading professional bodies, would facilitate the role that professional associations are already playing in the development of rules and policies to inform existing guidance.

### Isolation and a lack of professional support forces the health care professional to make ethical decisions on their own

Isolation and a lack of moral or practical support from colleagues or professional bodies have both been identified as risk factors in medical practice.<sup>84</sup> To achieve better compliance with the rule of law, states must ensure that their agents, including health professionals, are aware of the rules and standards that bind them. Both the state and the health professional should have access to an external advisory body to provide guidance on ethical issues related to detainee health care. Although the professional bodies have developed declarations, guidelines and regulations to guide professional conduct, guidelines and regulations cannot capture all situations. There is also need for advisory support systems in situations that raise difficult ethical dilemmas. State health professionals should have access to such a support system. The International Council of Nurses has recommended a similar system, holding that “National nurses’ associations need to ensure an effective mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with difficult human rights situations.”<sup>85</sup>

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<sup>83</sup> WJP, *Rule of Law Index*, *supra* note 2 at 3: The government officials and agent are held accountable under the law; 4. Military, police, prison officials, and their agents are held accountable under the law.

<sup>84</sup> *BMA Handbook*, *supra* note 6 at 50.

<sup>85</sup> International Council of Nurses, *Nurses and Human Rights*, Adopted in 1998, reviewed and revised in 2006. [<http://www.icn.ch/policy.htm>]. This position is reiterated in the International Council of Nurses, *Nurses’ role in the care of detainees and prisoners*, Adopted 1998, revised and revised in 2006.

The creation of an advisory body is consistent with international obligations to take preventative measures to prevent abuse.

Although there are no international instruments specifically mandating the creation of an advisory body on medical ethics in detention settings, the content of measures to ensure appropriate state action is informed by numerous instruments. For example, General Comment Number 2 to the Convention Against Torture requires states to take positive measures to “eliminate any legal or other obstacle that impede the eradication of torture and ill-treatment; and to take positive effective measures to ensure that such conduct and any recurrences thereof are effectively prevented.”<sup>86</sup> The non-binding comment provides that “the obligation to take effective preventative measures transcends the items enumerated specifically in the Convention or demands of this general comment.” [emphasis added]<sup>87</sup> In the field of health rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health, states can fulfil their obligations by:

- i. fostering recognition of factors favouring positive health results, e.g. research and provision of information;
- ii. ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable and marginalized groups.<sup>88</sup>

Establishing an advisory body on medical ethics to provide information and training to the state and its agents would be consistent with the general principles contained in both of these international agreements. An advisory body could play a key role in preventing ethical conflicts and helping ensure that state health professionals do not commit ethical violations. The World Medical Association emphasizes that the rules of medical ethics in times of armed conflict are “identical to medical ethics in times of peace.”<sup>89</sup> However, situations of armed conflict raise particular challenges for

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<sup>86</sup> The General Comments from the UN Convention Against Torture do not have the force and effect of treaty law; they are not binding. The Committee Against Torture created by the convention monitors state compliance only, and the members serve in their personal capacity. *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. General Comment No. 2. Implementation of Article 2 by State Parties.* CAT/C/GC/2 24 January 2008 at ¶ 4.

<sup>87</sup> Id. at ¶ 25. This comment focuses primarily on education about torture and obligations to prevent it, not specifically on advisory bodies: “For example, it is important that the general population be educated on the history, scope and necessity of the non-derogable prohibition of torture and ill-treatment, as well as that law enforcement and other personnel receive education on recognizing and preventing torture and ill treatment.”

<sup>88</sup> Substantive Issues arising in the Implementation of the International Covenant on Economic, Social, and Cultural Rights, General Comment No. 14 (2000), E/C.12/2000/4, 11 August 2000, at ¶ 37.

<sup>89</sup> WMA, *Regulations on Armed Conflict*, *supra* note 26.

health professionals. An advisory body devoted to providing assistance on issues pertaining to medical ethics in the military context could be of particular assistance, especially through the establishment of regular dialogue between the state, health care providers, and leading medical ethicists.

Recommendations:

States should establish a mechanism for dialogue on a regular basis among state officials responsible for detainee operations, medical professional organizations and associations, and other leading medical ethicists. Institutionalizing a process for such an exchange will foster transparency, help prevent ethical conflicts, and help ensure that state health professionals do not commit ethical violations and have, at a minimum, access to the same ethical resources and tools as their civilian counterparts.

## 6. Investigate and ensure accountability for medical misconduct

Accountability is an essential element of the rule of law, and has been recognized throughout the WJP Rule of Law Index. Specifically, the Rule of Law Index looks to the existence of “formal processes for reviewing the actions of government officials and agents.”<sup>90</sup> All personnel must be held accountable for official misconduct and violations of law.<sup>91</sup>

### A. Obligation to Investigate

Prompt investigation into allegations of violations of the law helps ensure accountability. An investigation provides several meaningful functions such as, identifying perpetrators, facilitating prosecution, protection of the rights of the accused,<sup>92</sup> and, the identification of misconduct<sup>93</sup> Further, an appropriate

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<sup>90</sup> WJP, *Rule of Law Index*, *supra* note 2 at 3.3: The government has formal processes for reviewing the actions of government officials and agents, and applies effective sanctions for misconduct, including removal of high officials through a process that is open to the public.

<sup>91</sup> *Id.* at 4.2: Military police, prison officials, and their agents are held accountable for official misconduct, including abuse of office for private gain, acts that exceed their authority, and violations of fundamental rights. 4.4: The government has formal processes for reviewing the actions of military, police, prison officials, and their agents, and applies effective sanctions for misconduct.

<sup>92</sup> *Id.* at 7.5: the laws protect the rights of the accused and prohibit the retroactive application of criminal laws.

<sup>93</sup> UN Office of the High Commissioner for Human Rights, *Manual on the Effective Investigation*

investigation may assist the state to fulfill their obligations under international law.<sup>94</sup> All of these functions of an investigation help to promote the rule of law both domestically and abroad.

### Duty to investigate under international law

The principle of accountability and the obligation to investigate wrongdoing finds broad support in numerous binding and non-binding international instruments. In the case of allegations of torture, or cruel, inhuman and degrading treatment, the Convention Against Torture obligates States to ensure there is a prompt and impartial investigation whenever there is reasonable grounds to believe that an act of torture has been committed.<sup>95</sup> Under the non-binding Declaration on the Protection of all Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the state should ensure that any person who alleges serious mistreatment has the ability to make a formal complaint, and have the allegation impartially examined by competent authorities of the concerned state.<sup>96</sup> Obligations to receive and investigate complaints are also contained in the UN Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment.<sup>97</sup>

An investigation of torture or other cruel, inhuman or degrading treatment or punishment in a detention facility should be conducted by an authority entirely separate from the institutional entity responsible for the operations of the detention facility.<sup>98</sup> Ideally, the investigation should be done by a competent independent commission of inquiry that is impervious to allegations of bias or inadequate expertise, particularly where high level public officials may have been involved in authorizing, or ordering the use of torture.<sup>99</sup>

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*and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ["Istanbul Protocol"]*, 9 August 1999. HR/P/PT/8. Online. UNHCR Refworld, available at: <http://www.unhcr.org/refworld/docid/4638aca62.html> (accessed 23 April 2009) at 120.

<sup>94</sup> WJP, *Rule of Law Index*, *supra* note 2 at 7.6: The laws protect the right to seek an effective remedy before a competent tribunal for violations of fundamental rights.

<sup>95</sup> CAT, *supra* note 35 at Articles 12 and 13;

<sup>96</sup> UN General Assembly, *Declaration on the Protection of all Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Res. 3452 (XXX) (9 December 1975) at Article 8.

<sup>97</sup> *Body of Principles*, *supra* note 82 at Principle 33 and 34.

<sup>98</sup> The *Istanbul Protocol*, *supra* note 93 at 5a, stresses the importance of an independent investigation such as a commission of inquiry noting that “In particular, they should be independent of any suspected perpetrators and the institutions or agencies they may serve”.

<sup>99</sup> *Id.* at Chapter III, C, ¶ 85., “In cases where involvement in torture by public officials is suspected, including possible orders for the use of torture by ministers, ministerial aides, officers acting with the knowledge of ministers, senior officers in State ministries, senior military leaders

A corollary of the obligation to investigate is the duty to report and document violations

Health professional bodies can assist states in realizing their duty to investigate by ensuring that their members have clear guidance on reporting, and documenting violations. In the context of detention, states cannot exclusively rely on victim reports of abuse. Victims may be reluctant to come forward for a range of reasons.<sup>100</sup> The World Medical Association has also called on national medical associations to support the drafting of more concrete ethical and legislative rules “affirming the ethical obligation on physicians to report or denounce acts of torture or cruel, inhuman or degrading circumstances of which they are aware...”<sup>101</sup> Although the presence of independent agencies, such as the International Committee for the Red Cross, can help facilitate accurate and timely reporting of abuse, the participation of health professionals in identifying and notifying authorities of violations is a vital complement to victim reports. Many of the leading professional health associations, both international and national, contributed to the drafting of the Istanbul Protocol, a manual on how to conduct an effective investigation and documentation of torture and other cruel, inhuman or degrading treatment. The Istanbul Protocol provides detailed guidelines and procedures for health professionals to identify and document cases of inhumane treatment.

Health professionals are particularly well suited to identify ethical violations by their colleagues because of their special expertise and knowledge of medical ethics. Health professionals have a professional duty, recognized by the World Medical Association and American Public Health Association to report violations of medical ethics,<sup>102</sup> and violations of the Geneva Conventions.<sup>103</sup> The UN Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment contains broad guidelines to report actual, or prospective violations of law.<sup>104</sup> Similar provisions are also found in national professional ethical codes such as the American Psychological Association’s Code of Conduct and the Canadian Medical Association’s

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or tolerance of torture by such individuals, an objective and impartial investigation may not be possible unless a special commission of inquiry is established.”

<sup>100</sup> See the World Medical Association *Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment*, adopted in Helsinki (2003), amended in Copenhagen, at 18, recognizing the difficulty victims may have in bringing forward complaints (October 2007).

<sup>101</sup> *Id.*

<sup>102</sup> WMA, *International Code of Medical Ethics*, *supra* note 20; American Public Health Association Policy Statement *Condemning the Cooperation of Health Professional Personnel in Physical and Mental Abuse and Torture of Military Prisoners and Detainees*, (2005).

<sup>103</sup> WMA, *Tokyo Declaration*, *supra* note 19 at 3.

<sup>104</sup> *Body of Principles*, *supra* note 82 at Principle 7.

Code of Ethics, both of which require their members to report serious ethics violations.<sup>105</sup>

## B. Obligation to hold perpetrators accountable

### Liability for violations of law and ethics

When violations of law and ethics take place, the individuals responsible for misconduct must be held accountable. Ethical lapses of health professionals may sometimes amount to illegal activity liable to criminal prosecution.

Prohibited involvement that may give rise to criminal liability can include violations of health professionals in the law of armed conflict. For example improper withholding of medical treatment<sup>106</sup> or conducting medical experimentation without free consent.<sup>107</sup> Forced administration of drugs and forced feeding can constitute illegal treatment that under certain circumstances could rise to the level of torture or cruel and inhuman treatment (see sections 3 and 4 above).

Health professionals may also be criminally liable for more indirect forms of involvement in abuse such as authorization, observation, or a failure to take preventative steps. Examples of indirect forms of involvement include authorizing a program of illegal treatment for a detainee; advising interrogators on the conduct of illegal treatment; designing or approving overall standards, systems or guidelines that condone illegal treatment; and failing to report illegal treatment.<sup>108</sup>

### States' obligation to prevent and punish torture and ill-treatment

The Convention Against Torture specifies states' obligations to prevent and criminalize torture and cruel treatment "inflicted by or at the instigation of or with the consent or acquiescence of" a public official.<sup>109</sup> The UN Committee Against Torture, in interpreting the Convention, opines that it applies to anyone "complicit in" abuse, whether or not "under colour of law".<sup>110</sup> This requires attention to the

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<sup>105</sup> American Psychological Association (2002) at 1.05, Reporting Ethical Violations. *Ethical Principles of Psychologists and Code of Conduct*. (available at: <http://www.apa.org/ethics/code2002.html>); Canadian Medical Association Code of Ethics (2004) at 48.

<sup>106</sup> See *Mika Mika v. Equatorial Guinea*, UN HRC No. 414/1990 and other cases cited and discussed in Nowak, *supra* note 32 at 182, particularly at footnote 152.

<sup>107</sup> See *ICCPR*, *supra* note 34 at Art. 7 and Nowak, *supra* note 32 at 190-191.

<sup>108</sup> See the discussion of liability under the *Convention Against Torture* in the subsequent paragraph.

<sup>109</sup> *Convention Against Torture*, *supra* note 35 at Art. 1(1) and Art. 16(1).

<sup>110</sup> UN Committee Against Torture, *General Comment No. 2*, *supra* note 32 at ¶ 17.

entire “chain of command,”<sup>111</sup> including to those who “knew or should have known that such impermissible conduct was occurring, or was likely to occur, and failed to take reasonable and necessary preventive measures.”<sup>112</sup>

Health professionals employed by a government entity or acting with the de facto consent or acquiescence of the state are public officials under the Convention.<sup>113</sup> Orders from superior officers or other public authorities “may not be invoked as a justification of torture”.<sup>114</sup>

Under the Convention Against Torture, states are required to have domestic laws that ensure the prevention and criminalization of torture and degrading treatment.<sup>115</sup> Article 5 of the Convention specifies various situations where states must take on jurisdiction for criminal sanctions. This includes offenses committed in a territory under its jurisdiction.<sup>116</sup> Jurisdiction for this purpose includes any place where the state exercises de jure or de facto effective control, whether directly or indirectly and whether in whole or in part. Specifically included in this definition are “military bases, detention facilities or other areas”.<sup>117</sup>

The Convention further provides that any state may arrest someone suspected of torture offenses committed within its jurisdiction. The State may prosecute or, if it chose, extradite the suspect.<sup>118</sup> In addition, torture is considered to be a crime of universal jurisdiction as a matter of customary law, thus allowing for perpetrators (including health professionals) to be prosecuted by any state.<sup>119</sup>

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<sup>111</sup> *Id.* at ¶ 7 and 9.

<sup>112</sup> *Id.* at ¶ 26. See also Nowak and McArthur, *supra* note 32 at page 78; they note that the position of the United States in drafting and adopting the CAT was that “consent or acquiescence” applies to any official who knows of abuse and does not intervene to prevent it.

<sup>113</sup> *Convention Against Torture*, *supra* note 35 at Art. 1(1) ; UN Committee Against Torture, *General Comment No. 2*, *supra* note 32 at ¶ 7 and 9; Nowak and McArthur, *supra* note 32 at 78.

<sup>114</sup> *Convention Against Torture*, *supra* note 35 at Art. 2(3).

<sup>115</sup> *Id.* Art. 2(1)

<sup>116</sup> *Id.* at Art. 5(2) obliging States to take jurisdiction in the following circumstances: when the offences are committed in any territory under its jurisdiction or on board a ship or aircraft registered in that State; when the alleged offender is a national of that State; when the victim is a national of that State if that State considers it appropriate. Each State Party shall likewise take such measures as may be necessary to establish its jurisdiction over such offences in cases where the alleged offender is present in any territory under its jurisdiction and it does not extradite him pursuant to article 8.

<sup>117</sup> UN Committee Against Torture, *General Comment No. 2*, *supra* note 32 at ¶ 7 and 16.

<sup>118</sup> *Convention Against Torture*, *supra* note 35 at Arts. 6 and 7.

<sup>119</sup> See e.g. preamble to the *Rome Statute of the International Criminal Court*, 17 June 1998, 2187 U.N.T.S. 90 (entered into force 1 June 2002); *Restatement (Third) of the Foreign Relations Law of the United States*, *supra* note 5 at § 702, comment (o) (violations of the prohibition of torture “are violations of obligations to all other States”); *R. v. Bow Street Metropolitan*

Where health professionals are alleged to have been involved in rights violations, their conduct should be investigated by the state. Where there is sufficient evidence, perpetrators of gross violations of humanitarian law should be prosecuted.<sup>120</sup>

Professional associations with regulatory and disciplinary functions should also investigate and take action against professionals who are alleged to have been complicit in abuse.<sup>121</sup> With respect to prospective professional association members, the World Medical Association's Statement on the Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences recommends that "National medical associations should use their own licensing powers to ensure that physicians against whom serious allegations of participation in torture, war crimes or crimes against humanity have been made are not able to obtain licenses to practice until they have satisfactorily answered these allegations."<sup>122</sup>

### The right to an effective remedy

In addition to ensuring accountability, investigations can also assist states in ensuring that victims have access to effective remedies. The right to a remedy for violations of fundamental human rights is seen throughout international law<sup>123</sup> and has been recognized as a central component of the rule of law.<sup>124</sup> Such remedies include the right to rehabilitation, including medical and psychological care as well as social services.<sup>125</sup>

### Rehabilitation

Detainees who have been subject to torture or cruel, inhuman or degrading treatment while in detention may face years of physical and psychological rehabilitation. The involvement of health professionals in these violations raises significant complications for detainees seeking rehabilitation. Detainees whose trust

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*Stipendiary Magistrate and others, ex parte Pinochet Ugarte (Pinochet No. 3)*, [1999] 2 All ER 97 per Lord Browne Wilkinson at 109 ("[t]he jus cogens nature of the international crime of torture justifies States in taking universal jurisdiction over torture wherever committed.").

<sup>120</sup> 2006 Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, GA Resolution 60/147 16 December 2005 ("2006 Basic Principles").

<sup>121</sup> See the British Medical Association, *Medicine Betrayed* (1992), recommendation 22.

<sup>122</sup> World Medical Association, *Statement on the Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences* (Hamburg) (1997).

<sup>123</sup> Article 8, Universal Declaration of Human Rights, *supra* note 74 ; 2006 Basic Principles , *supra* note 120 at ¶ 3; ICCPR, *supra* note 34 at Article 2(3); General Comment No. 14 § 59.

<sup>124</sup> WJP, *Rule of Law Index*, *supra* note 2 at 7.6: The laws protect the right to seek an effective remedy before a competent tribunal for violations of fundamental rights.

<sup>125</sup> Nowak, *supra* note 32 at 71; Mr. R. S. v. Trinidad and Tobago, Communication No. 684/1996, U.N. Doc. CCPR/C/74/D/684/1996 (2002) at ¶ 9.

in health professionals and the health system has been broken may also be less likely to report violations or seek out appropriate assistance. It is the obligation of the state to help address these issues and facilitate detainee access to necessary resources, including the costs of medical, psychological and social services.<sup>126</sup>

### Satisfaction

The right to satisfaction embraces many of the basic rules of law principles already discussed. The right would include “effective measures aimed at the cessation of continuing violations.”<sup>127</sup> In the case of repatriation, it is the obligation of the transferring state to ensure that no detainee is transferred to any state where there are substantial grounds for believing the detainee would be in danger of being subjected to torture.<sup>128</sup>

### Recommendation 6: Investigate and Ensure Accountability for Medical Misconduct

States should conduct a prompt investigation into alleged detainee abuse, and ensure appropriate domestic legislation for the prosecution of offenders. To the extent that allegations of abuse are widespread, a public commission of inquiry may be warranted to make recommendations and to avoid future violations. When detainee abuse is substantiated, States must take appropriate action. Professional associations should also undertake investigations of their members and provide support for whistleblowers.

## 3. Conclusions

Adherence to the rule of law may be informed or complemented by a review of codes of conduct endorsed by medical professional organizations and associations, statements of international and non-governmental organizations, or other similar non-binding instruments. Professional health associations and international bodies have developed several instruments guiding the behaviour of health professionals working in detention centres. Instruments such as the Declaration of Tokyo, the Declaration of Malta, and the Standard Minimum Rules for the Treatment of

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<sup>126</sup> 2006 *Basic Principles*, *supra* note 120 ¶ 20(e).

<sup>127</sup> *Id* ¶ 22 (a).

<sup>128</sup> *Convention Against Torture*, *supra* note 35 at 3; *ICCPR*, *supra* note 34 at 7; Human Rights Committee, General Comment No. 20, Art 7 § 9 (1994) HRI/GEN/Rev.1; Human Rights Committee, General Comments No. 31 ¶ 12 (2004) CCPR/C/21/Rev.1/Add 13 (May 2004); Conclusions and Recommendations of the Committee Against Torture: Denmark ¶ 13 CAT/C/DNK/CO/5 (July 2007).

Prisoners are consistent with international human rights law and the law of armed conflict, and can provide valuable recommendations to the state and state agents on the standard of health care in detention facilities. States should consider these instruments when developing policies on clinical autonomy, the involvement of health professionals in interrogation, hunger strikes, and the involuntary administration of medications. States should ensure that allegations of abuse or misconduct are investigated, and when substantiated, ensure that corrective action is taken. Finally, states should consider establishing an advisory body on medical ethics to assist health professionals in avoiding ethical violations.

## Appendix A

### Legal Instruments on Medical Ethics and Treatment of Detainees

Instrument	Year	Body
<b>International Treaties</b>		
International Covenant on Civil and Political Rights	1966	166 State Parties
International Covenant on Economic, Social and Cultural Rights	1966	160 State Parties
Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1984	146 State Parties
The Geneva Conventions (4 treaties)	1949 (started in 1864)	194 State Parties
<b>Resolutions of UN Bodies</b>		
Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1982	UN General Assembly
Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment	1988	UN General Assembly
Standard Minimum Rules for the Treatment of Prisoners	1957	UN Economic and Social Council

## Health Professionals and Human Rights

Basic Principles for the Treatment of Prisoners	1990	UN General Assembly
Principles for the Protection of Persons with Mental Illness And the Improvement of Mental Health Care	1991	UN General Assembly
Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“Istanbul Protocol”)	1999	Published by the UN High Commissioner for Human Rights

### Resolutions of International Health Professional Organizations

International Code of Medical Ethics	1949, last amended 2006	World Medical Association
Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (“Declaration of Tokyo”)	1975, last amended 2006	World Medical Association
Regulations in Times of Armed Conflict	1956, last amended 2006	World Medical Association
Ethical Principles for Medical Research Involving Human Subjects (“Declaration of Helsinki”)	1964, last amended 2008	World Medical Association

## Health Professionals and Human Rights

Declaration on the Rights of the Patient	1981, last amended 2005.	World Medical Association
Declaration on Hunger Strikers (“Declaration of Malta”)	1991, last amended 2006	World Medical Association
Resolution on the Responsibility of Physicians in the Documentation And Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment	2003, last amended 2007.	World Medical Association
Nurses' Role in the Care of Detainees and Prisoners	1998, amended 2006	International Council of Nurses
Nurses and Human Rights	1998, amended 2006	International Council of Nurses
Torture, Death Penalty and Participation by Nurses in Executions	1998, last amended 2006	International Council of Nurses
Madrid Declaration on Ethical Standards for Psychiatric Practice	1996, last amended 2005	World Psychiatric Association
Declaration of Hawaii / II	1983	World Psychiatric Association

### Resolutions of U.S. Health Professional Organizations

## Health Professionals and Human Rights

Code of Medical Ethics, Opinion 2.068, Physician Participation in Interrogation	2006	American Medical Association
Policy H-65.997 Human Rights (endorses the Declaration of Tokyo)		American Medical Association
Psychiatric Participation in Interrogation of Detainees: Position Statement.	2006	American Psychiatric Association
Petition Resolution, 17 September 2008	2008	American Psychologists Association

NOTE: This list is a guide, and is not comprehensive.

## Appendix B

### Summary of Recommendations to States and Professional Health Organizations

The codes of medical ethics developed by professional associations can inform and complement states in meeting their obligations under the law. In addition, states can minimize violations of the rule of law by promoting clinical autonomy, ensuring that health professionals are supported with ethical decision-making resources and tools, and ensuring the state has procedures for reporting violations in confidence. . States should also review existing protocols and policies in an effort to harmonize, to the extent consistent with legal obligations, state practice and ethical guidelines. States should consider establishing an advisory body on medical ethics to advise the state and clinicians on medical ethics in detention settings, to include the establishment of appropriate internal and external oversight mechanisms. Independent investigations into allegations of misconduct and ensuring adequate remedies and accountability for substantiated violations will promote state compliance with the rule of law.

#### Recommendation 1: Restore Clinical Autonomy

States must recognize and manage the risk posed by dual loyalties. Detention policies, including the role of the clinician in the chain of command, and the decision making authority for medical treatment of detainees, should be reviewed and modified, where appropriate, to protect full clinical autonomy. Health professionals should be informed of their obligation to work in the best interest of their patients, and encouraged to exercise professional judgement.

#### Recommendation 2: End the Participation of Health Professionals in Interrogations

States should undertake a review of the involvement of health care professionals in interrogation, being mindful of the need to ensure compliance with international legal obligations. States should avoid putting health professionals into situations that will create ethical conflicts with their professional ethical codes. Existing policies should be harmonized with the recommendations and ethical codes of professional codes to the extent practicable.

Recommendation 3: Reform the Protocols for Hunger Strikes to Respect Patient Autonomy

States must protect the rights of detainees. In developing hunger strike policies for detention facilities, states should review health professional association guidelines, and to the extent possible, design or modify policies in accordance with national and international medical ethics standards. During a hunger strike, states should consider inviting independent health professionals to monitor activities. Health professionals should be obligated to consult within their chain of command to obtain professional guidance when ethical dilemmas about the treatment of hunger strikers arise.

Recommendation 4: Prohibit Involuntary Administration of Medications

States should review their policies concerning the administration of drugs to detainees in light of their obligations under international law. Involuntary drugging of detainees should only be used in circumstances that are consistent with the principles of medical ethics and national and international law.

Recommendation 5: Establish an Advisory Body on Medical Ethics in Detention Settings

States should establish a mechanism for dialogue on a regular basis among state officials responsible for detainee operations, medical professional organizations and associations, and other leading medical ethicists. Institutionalizing a process for such an exchange will foster transparency, help prevent ethical conflicts, and help ensure that state health professionals do not commit ethical violations and have, at a minimum, access to the same ethical resources and tools as their civilian counterparts.

Recommendation 6: Investigate and Ensure Accountability for Medical Misconduct

States should conduct a prompt investigation into alleged detainee abuse, and ensure appropriate domestic legislation for the prosecution of offenders. To the extent that allegations of abuse are widespread, a public commission of inquiry may be warranted to make recommendations and to avoid future violations. When detainee abuse is substantiated, States must take appropriate action. Professional associations should also undertake investigations of their members and provide support for whistleblowers.

## Appendix C

### Members of the Working Group<sup>1</sup>

Georges C. Benjamin, MD, FACP, FACEP(E), Hon FRSPH, is the executive director of the American Public Health Association (APHA), the nation's oldest and largest organization of public health professionals. He previously was the secretary of the Maryland Department of Health and Mental Hygiene, from 1999 - 2002 following four years as its deputy secretary for public health services. Benjamin, is a graduate of the Illinois Institute of Technology and the University of Illinois, College of Medicine. He is board-certified in internal medicine and a fellow of the American College of Physicians; he is a Fellow Emeritus of the American College of Emergency Physicians; a honorary fellow of the Royal Society of Public Health; and a member of the Institute of Medicine of the National Academies

Colonel John L. Charvat Jr., US Army, Retired. Colonel Charvat retired from the United States Army in 2007 after having served nearly 34 years on active duty. Commissioned in the Infantry upon graduation from West Point, Colonel Charvat became a Judge Advocate in 1985 following graduation from Duke University School of Law. He served as the Senior Military Assistant to the General Counsel of the Department of Defense from June 2002 to April 2004 and then deployed to Iraq for 14 months, where he served as the Staff Judge Advocate, Multi-National Force – Iraq. Upon returning from Iraq, Colonel Charvat became the Chief, International and Operational Law Division, Office of The Judge Advocate General, Department of the Army, and served there until his retirement. Colonel Charvat also earned an LLM in Military Law from The Judge Advocate General's School and a MS in National Resource Strategy from the Industrial College of the Armed Forces. He and his wife Jan live near Asheboro, North Carolina.

Justice William H. Goodridge. Appointed Justice of the Supreme Court of Newfoundland and Labrador in 2007. LL.B from Osgoode Hall Law School. Called to the Newfoundland Bar in 1982. Appointed lecturer with Memorial University of Newfoundland 1988. Appointed Queen's Counsel 2002. Elected President of the Law Society of Newfoundland 2002. Elected President of the Federation of Law Societies of Canada 2006. Justice Goodridge is a member of the Canadian Bar Association and in that capacity served from 2002 to 2008 on the International

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<sup>1</sup> Note that the contribution of working group members is made in their individual capacity and does not reflect the view of their respective organizations.

Development Committee. He has assisted the Canadian Bar Association in its efforts toward enhancing governance of the various legal institutions and promoting rule of law. He has been both a presenter and facilitator for rule of law workshops in Austria, Pakistan, Tanzania, Kenya, Ethiopia and Uganda.

Capt. Patrick J. Neher, JAGC, USN, Director, International and Operational Law, Office of the Judge Advocate General, Department of the Navy. Captain Neher has served in the Judge Advocate General's Corps of the U.S. Navy for 25 years, with a focus on operational assignments in the Persian Gulf and Pacific, and policy assignments in Washington DC. His expertise is in the law of armed conflict and the law of the sea. Captain Neher has a B.A. from the University of Illinois at Chicago, a J.D. from Illinois Institute of Technology, Chicago-Kent College of Law, and an LL.M. from The George Washington University School of Law.+

Michael Posner, President, Human Rights First, United States of America. Mr. Posner has been a visiting lecturer at Columbia University Law School since 1984. He has been at the forefront of the international human rights movement for almost 30 years. Since 2007, Posner has assisted in the creation of the Principles on Freedom of Expression and Privacy to protect and advance the human rights of free expression in the information and communications technology industry. In 1998, Posner led the Human Rights First delegation to the Rome conference at which the statute of the International Criminal Court (ICC) was adopted. As a member of the White House Apparel Industry Partnership Task Force, Posner helped found the Fair Labor Association to promote corporate accountability for working conditions in the apparel industry. He also proposed, drafted, and campaigned for the Torture Victim Protection Act, which was adopted by Congress and signed into law in 1992. Posner played a key role in proposing and campaigning for the first US law providing for political asylum, which became part of the Refugee Act of 1980. Posner is a frequent public commentator and his opinion essays have appeared in newspapers such as the New York Times, Los Angeles Times and Chicago Tribune. Posner has also testified dozens of times before the US Congress.

Kenneth R. Thompson II, Senior Vice President and Global Chief Legal Office, LexisNexis Group. As LexisNexis Global Chief Legal Officer, Ken Thompson has transformed the Legal Department into a global legal services organization, trusted by leadership and deeply embedded in the company's day-to-day operations. The Global Legal Department (GLD) emphasizes the big picture – including a business perspective, the establishment of a corporate pro bono program, professional leadership and commitment to the rule of law, has enabled the company's lawyers to operate strategically both within and outside the LexisNexis organization – yet, free

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<sup>+</sup> Captain Neher's contributions to the working group were made in his personal capacity and the views contained in the report do not reflect the official position of the U.S. Government.

to challenge and ask the right questions. In 2001, Ken joined LexisNexis as a partner from a Cincinnati law firm. He has served as LexisNexis Group Chief Legal Officer since 2005. In his role as Global CLO, Ken continues to focus on his core areas of expertise: intellectual property, acquisitions and divestiture, anti-trust, and Internet security issues. As a member of the LexisNexis Group Management Committee, Ken leads and advises at the highest levels of the company. He also remains the principal legal advisor to the LexisNexis Global Chief Executive Officer. Ken has a B.A. degree from Capital University and a JD from the University of Cincinnati College of Law. His broad expertise makes him an authoritative and highly engaging public speaker on a range of issues: intellectual property, acquisitions and divestitures, anti-trust, and Internet security. Ken is also active in the IBA, the ABA, ACC and other professional organizations. Ken is also a member of the Advisory Board for Corporate Pro Bono.

Stephen N. Zack is a Board Certified Civil Trial Lawyer and Administrative Partner of Boies, Schiller & Flexner, LLP's Miami office. He was the youngest President of the Florida Bar. He served as General Counsel to Governor Bob Graham, was appointed by Lawton Chiles to Florida Constitutional Revision Commission and chaired the Florida State Ethics Commission. Stephen Zack also served as President of the National Conference of Bar Presidents and as the Chair of the American Bar Association's House of Delegates. The ABA Nominating Committee voted unanimously at the Mid-Year Meeting in Boston to confirm Mr. Zack as the next President-Elect nominee of the ABA, becoming the Association's first Hispanic American President.

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