

**WHEN IS NOT CARING ETHICAL?:
THE MEDICAL ETHICS AND LEGAL FRAMEWORK OF
REFUSING TO TREAT DETAINEES SUBJECTED TO
INTERROGATIONS AND TORTURE**

SHANNON M. COIT*

1. INTRODUCTION

Medical professionals obey the Hippocratic Oath, standing for the principle of 'do no harm.'¹ But, at a point, refusing to provide care becomes the more ethical choice for medical professionals responsible for treating detainees and prisoners of war. Torture and improper interrogation remain a constant and present practice during war, internationally and by the United States, especially in recent Administrations.² Reports find that the "[l]egal, ethical, and medical condemnation have not been as effective as their proponents hoped: torture is widespread in more than a third of countries, and medical implication is described in at least 40 percent of reported torture cases."³ Currently, the United States, other countries, and the international community have policies in place requiring medical professionals to provide adequate medical

* University of Pennsylvania Law School, J.D. 2014; University of Pennsylvania Perelman School of Medicine, M.B.E. 2014; The University of Michigan, B.A. 2006. I would like to thank Professor Claire Finkelstein for her guidance and facilitating this comment; Kathy Nguyen, Shannon Doherty, and the entire Penn JIL editorial staff for its hard work on this comment and dedication to JIL; and my husband, Daniel Spradling, for his continued support and early editing. All opinions and mistakes are my own.

¹ *Greek Medicine*, NAT'L INSTS. OF HEALTH: HIST. OF MED. DIV., http://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Dec. 18, 2013) (including the history of and the current edition of the Hippocratic Oath, with the phrase "do no harm").

² Chiara Lepora & Joseph Millum, *The Tortured Patient: A Medical Dilemma*, 41 HASTINGS CTR. REP. 38, 38 (2011).

³ *Id.* at 39 (footnotes omitted).

care during interrogations or for prisoners of war.⁴ However, if detainees are subjected to multiple interrogations or torture that create physically and mentally stressful situations, then when doctors and medical professionals render care, they are only prolonging this suffering.

When 'do no harm' is upheld by not rendering care, the international community and the United States do not have proper policies and practices in place that permit and protect the medical professionals making these decisions. This comment will examine the intersection between medical ethics, morality, and the law in circumstances of interrogation and with detainees, especially during the time of war when aims of national security and war are particularly prevalent. International communities and the United States should implement policies that will protect medical professionals from liability for torture or complicity to torture offenses in these limited circumstances where refusing care is required. These policies should also include notice and reporting requirements to ensure that these decisions are not made within a vacuum and allow for correction of improper treatment before the refusal of treatment.

Section 2 will examine the background of torture statutes, medical ethics, and the combatant status of detainees. Exploring an example of refusing to provide care in Libya will provide helpful insight into the current state of policies as well as real circumstances doctors are facing in the field. This section will also evaluate these current policies regarding whether doctors and medical professionals can refuse to provide care.

Section 3 provides the ethical evaluation of these proposed actions, or more properly described as inactions. Drawing analogy between the ethics and policies of the medical community's refusal of allowing psychiatrists to participate in the death penalty serves as an important and relevant example to understanding the moral obligations in refusing care. I also advocate in this section for an intention-based model of ethical evaluation over a consequence-based model to justify these actions. However, refusing to provide care can also be justified under a consequence-focused evaluation. This section introduces some war conventions, rule of war principles, and other duties of medical professionals that apply in these circumstances.

⁴ See *infra* notes 11, 16-18 and accompanying text.

Not only is this course of action ethically justified, but Section 4 will explore why it should also be legal to refuse to provide care, and why providing care might already be illegal. Providing care equates to complicity to torture or violates torture statutes in extreme situations. Many situations are close calls and fall into a gray area that require keen professional judgment, but black and white situations do exist for evaluating what the laws should prevent.

Section 5 provides policy proposals based on the ethical and legal permissibility. These policies should exist as exceptions to providing adequate care in circumstances where trained medical professionals determine that repeated offenses are likely to occur and that treatment will only contribute to ongoing interrogation and torture efforts. These policy exceptions are not without safeguards. These safeguards include notice requirements by the medical professionals to offending individuals and governments that the physicians will discontinue care if the mistreatment of detainees does not cease. Doctors will also have reporting requirements, including following established lines of reporting for medical professionals. These policy exceptions will allow for doctors and medical professionals to preserve their medical autonomy while still protecting detainees and the international community from continued human rights abuses. This section also explores recently proposed state legislation protecting medical professionals in situations regarding torture. By refusing to provide care, these professionals are providing the right medical and ethical decision for these detainees to lessen their suffering, and this paper provides the legal policies that allow them to do it.

2. BACKGROUND

2.1. *Combatants and Unarmed Combatants*

Defining the status of detainees is relevant to the discussion of what type of medical care detainees should or should not receive because, traditionally, different ethics apply to individuals at a time of war based on their status.⁵ An enemy combatant is “a person engaged in hostilities against [a country] during an armed

⁵ MICHAEL WALZER, *JUST AND UNJUST WARS: A MORAL ARGUMENT WITH HISTORICAL ILLUSTRATIONS* (3d ed. 2000).

conflict.”⁶ The Principle of Distinction is a Rule of War principle that allows for the killing of combatants,⁷ based on their status, at any time, regardless of what they are doing, even if that action is sleeping, while prohibiting the intentional killing of civilians.⁸ Thus, how an individual is treated in war is based on their status, not by the activity in which they are engaged. An exception under the Principle of Distinction applies to combatants that have surrendered or that are injured and out of combat.⁹ Because of this exception, surrendered and/or injured combatants cannot be killed at any point, and rather certain duties and protections attach to these individuals.¹⁰ These protections include receiving adequate medical care and humane treatment.¹¹ Thus, for doctors and medical professionals, this loss of combatant status creates a type of duty to protect these detainees by creating a duty to provide adequate medical care.¹² This paper will explore what adequate medical care means in situations of continued and repeated incidents of improper interrogation and torture.

2.2. *Torture Statutes*

Currently, the United States, European Union, and other sources of international law have extensive statutes, policies, and practices governing the treatment of torture that continue to

⁶ DEP'T OF THE ARMY, FIELD MANUAL 2-22.3 (FM 34-52): HUMAN INTELLIGENCE COLLECTOR OPERATIONS, at viii, 5-20 (2006) [hereinafter ARMY FIELD MANUAL], available at <http://www.fas.org/irp/doddir/army/fm2-22-3.pdf>.

⁷ JEAN-MARIE HENCKAERTS & LOUISE DOSWALD-BECK, INT'L COMM. OF THE RED CROSS, CUSTOMARY INTERNATIONAL HUMANITARIAN LAW VOLUME 1: RULES (2005), available at http://www.icrc.org/customary-ihl/eng/docs/v1_rul_rule1 (outlining 161 rules for international humanitarian law, including rule 1 titled “The Principle of Distinction between Civilians and Combatants”).

⁸ WALZER, *supra* note 5, at 138.

⁹ *Id.* (“[O]nce war has begun, soldiers are subject to attack at any time (unless they are wounded or captured).”).

¹⁰ See ARMY FIELD MANUAL, *supra* note 6, at viii (“All captured or detained personnel, regardless of status, shall be treated humanely, and in accordance with the Detainee Treatment Act of 2005 . . .”).

¹¹ GUIDELINES TO EU POLICY TOWARDS THIRD COUNTRIES ON TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (2008), available at <http://www.consilium.europa.eu/uedocs/cmsUpload/TortureGuidelines.pdf>.

¹² See *supra* note 11 and *infra* notes 16-17, 22-24 and accompanying text.

develop, even within the last ten years. For the United States, during the Bush Administration, Defense Secretary Donald Rumsfeld ordered that doctors had to certify prisoners “medically and operationally” suitable for torture and to be present for sessions.¹³ At Abu Ghraib, a military prison in Iraq, interrogations had to be preapproved by a physician and a psychiatrist, though reports since have found that these medical approvals did not ensure or even give notice that the interrogations were medically ethical.¹⁴ Similarly, military doctors’ failure to report torture, even informally, became a repeated issue.¹⁵ During Obama Administration, following the public outcry regarding U.S. practices at Guantanamo, the President took action to improve the U.S. stance toward interrogation. In 2006, his Administration changed the Department of Defense’s detention policy to ban “depriv[ing] detainees of the necessary food, water and medical care,” though a 2014 Senate Select Intelligence Committee report contained allegations that the Central Intelligence Committee (CIA) continues to use medical personnel in interrogations.¹⁶ The Army Field Manual includes these

¹³ Secretary of Defense Donald Rumsfeld, *Memorandum for the Commander, US Southern Command*, DEP’T OF DEFENSE, tab B(x)(iii), (vi) (Apr. 16, 2003), available at <http://www.defense.gov/news/jun2004/d20040622doc9.pdf> (quoting the unclassified document written by Secretary Rumsfeld regarding “Counter-Resistance Techniques in the War on Terrorism”).

¹⁴ Justine Sharrock, *First, Do Harm*, MOTHER JONES, July/Aug. 2009, <http://www.motherjones.com/politics/2009/07/first-do-harm>.

¹⁵ See, e.g., Sophie Arie, *Doctors Need Better Training to Recognise and Report Torture*, BMJ, Sept. 9, 2011, <http://www.bmj.com/content/343/bmj.d5766> (“Military doctors have also failed to report signs of abuse in detainees); CBS News, *U.S. Doctors Participated in Torture of Detainees, Report Claims*, CBCNEWS (Nov. 4, 2013), <http://www.cbc.ca/news/world/u-s-doctors-participated-in-torture-of-detainees-report-claims-1.2355511> (“The task force alleges that DoD practices and policies . . . co-opted [doctors] into violating professional standards and ethics through actions that included . . . [f]ailing to report abuses against detainees ‘under recognized international standards.’”); Harriet Sherwood, *Israeli Doctors ‘Failing to Report Torture of Palestinian Detainees,’* THE GUARDIAN (Nov. 3, 2011, 4:53 AM) (reporting on accusations that Israeli doctors are failing to report injuries of detainees that relate to abusive interrogations and torture).

¹⁶ Lieutenant General John Kimmons, Army Deputy Chief of Staff for Intelligence, Defense Department News Briefing on Detainee Policies (Sept. 6, 2006) (transcript available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/09/06/AR2006090601442.html>); SEN. SELECT COMM. ON INTELLIGENCE, COMMITTEE STUDY OF THE CENTRAL INTELLIGENCE AGENCY’S DETENTION AND INTERROGATION PROGRAM (2014) [hereinafter 2014 SENATE CIA REPORT], available at <http://www.intelligence.senate.gov/study2014/executive-summary.pdf>. The report includes accusations that medical professionals

requirements and prohibits implementing any forms of interrogation outside what is described in the manual.¹⁷ Though no case in the U.S. courts has held medical professionals liable for torture, the medical community collectively disapproves of these actions by medical professionals and works to find solutions to preventing these deviations from ethical behavior in the future.¹⁸

Torture laws and policies also restrict doctors and medical professionals, such as nurses, from participating in interrogations. Reports from Guantanamo found that psychiatrists and other physicians were providing information about detainees to make interrogation techniques "more efficient" and permitted these professionals to closely monitor the interrogations.¹⁹ As The Constitution Project states, "the use of psychologists, psychiatrists and other physicians, and other medical and mental health personnel, [] help assist and guide interrogations that were often brutal."²⁰ The medical community quickly spoke out against these types of actions, once they were known, and supported the ban on participating in such activities because this type of professional behavior violates medical ethics.²¹ Thus, though

continue to assist in brutal interrogation techniques, including specific instances when medical professionals administered unnecessary and improper rectal rehydration on detainees. Jennifer Bendrey, *Dianne Feinstein: No, the CIA Did Not Use Rectal Hydration as 'a Medical Procedure' on Detainees*, HUFFINGTON POST, Dec. 12, 2014, http://www.huffingtonpost.com/2014/12/12/dianne-feinstein-cia-torture-report_n_6318336.html. The CIA denied these accusations. *Id.*

¹⁷ See generally ARMY FIELD MANUAL, *supra* note 6 (explicitly stating that the interrogation approaches and techniques that are authorized for use are those authorized and listed in this Field Manual).

¹⁸ See AM. MED. ASS'N, AMA CODE OF MEDICAL ETHICS, Opinion 2.067: Torture (1999) [hereinafter CODE OF MEDICAL ETHICS] (stating the AMA's opposition to any type of participation in torture in Opinion 2.067: Torture); see also THE CONSTITUTION PROJECT, THE REPORT OF THE CONSTITUTION PROJECT'S TASK FORCE ON DETAINEE TREATMENT: ABRIDGED VERSION 30-31 (2013) [hereinafter THE CONSTITUTION PROJECT], available at <http://detainee-taskforce.org/pdf/abridged-final.pdf> (asserting the need for professional medical involvement by medical professionals in detention and interrogation operations processes).

¹⁹ THE CONSTITUTION PROJECT, *supra* note 18, at 30.

²⁰ *Id.* at 30-31 ("The involvement of medical personnel was ostensibly to make the process more efficient (psychologists could provide guidance to interrogators as to how best obtain information) . . ."); see Sharrock, *supra* note 14 ("[Defense Secretary Donald] Rumsfeld ordered that doctors had to certify prisoners 'medically and operationally' suitable for torture and be present for the sessions.").

²¹ THE CONSTITUTION PROJECT, *supra* note 18, at 31 ("[The American

medical professionals are required to provide adequate medical care, they cannot overstep those boundaries.

Internationally, torture is regularly defined as including “acts of omission, such as prolonged denial of . . . medical assistance.”²² Article 7 of the UN International Covenant on Civil and Political Rights (ICCPR) binds international communities from using torture, administering cruel and unusual punishment, and conducting medical experiments without a patient’s consent.²³ Part of these policies stems from a tradition of providing medical care to detainees.²⁴ Various statutes require ‘adequate medical care’ in these various torture and detention statute and laws. International courts and tribunals additionally find violations of torture statutes when medical care is not provided. The International Criminal Tribunal of the Former Yugoslavia reported on woefully inadequate medical assistance in *Prosecutor v. Kvočka, ICTFY*.²⁵ In *Achuthan v. Malawi*, the African Commission on Human and Peoples’ Rights found a violation of Article 5 of the

Psychiatric Association] decided, with little dissent, that its members could not ethically participate in any way in the interrogations.”).

²² Torture includes “acts of omission, such as prolonged denial of rest, sleep, food, sufficient hygiene, or medical assistance” David Weissbrodt & Cheryl Heilman, *Defining Torture and Cruel, Inhuman, and Degrading Treatment*, 29 LAW & INEQ. 343, 378 (2011) (citing Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Comm’n on Human Rights, 42d Sess., U.N. Doc. E/CN.4/1986/15, at 106–17 (Feb. 16, 1986) (by P. Kooijmans)). See *ECCC Training Materials*, INT’L CRIM. L. SERVS. & OPEN SOC’Y JUSTICE INITIATIVE, ¶ 60 (2009), available at <http://www.iclsfoundation.org/wp-content/uploads/2012/02/eccc-trainingmaterials-icls-osji-09-prt5.pdf> (“The following acts have been found to constitute torture by the UN Human Rights Committee, the European Court of Human Rights and the Special Rapporteur on Torture for the UN Commission on Human Rights: . . . prolonged denial of medical assistance . . .”).

²³ International Covenant on Civil and Political Rights art. 7, opened for signature Dec. 16, 1966, S. Exec. Doc. E, 95-2 (1978), 999 U.N.T.S. 171.

²⁴ See GUIDELINES TO EU POLICY, *supra* note 11 (requiring medical care for detainees); see also Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Review of the Standard Minimum Rules for the Treatment of Prisoners: 2013I*, Comm’n on Human Rights, 68th Sess., U.N. Doc. A/68/295, ¶¶ 46, 50 (Aug. 9, 2013) (by Juan E. Méndez) (stating that “a lack of financial resources cannot be an excuse for not . . . providing food and medical treatment” and that “[t]he State must provide adequate medical care”); STEVEN H. MILES, OATH BETRAYED: TORTURE, MEDICAL COMPLICITY, AND THE WAR ON TERROR (2006) (stating that the United States has a “tradition of medical care for prisoners of war”).

²⁵ *Prosecutor v. Kvočka*, Case No. IT-98-30/1-T, Trial Chamber Judgment, ¶¶ 61–67 (Int’l Crim. Trib. for the Former Yugoslavia, Nov. 2, 2001).

African Charter, which prohibits “torture, cruel, inhuman or degrading punishment and treatment” when a detainee was denied “access to adequate medical care.”²⁶ The UN Human Rights Committee held that being deprived of “adequate medical care,” *inter alia*, resulted in torture in *Mika Miha v. Equatorial Guinea*.²⁷ This strong history in the international community supports physicians in providing care, though these same protections and provisions do not always provide for exceptions to refuse to provide care when medical care *assists* torturers.

2.3. Medical Ethics

The Hippocratic Oath is taken by most doctors and medical professionals, and is commonly known for standing for ‘do no harm.’²⁸ Much like the professional ethics of lawyers, the physician-patient relationship enjoys protections and privileges of confidentiality, duties of communication, and protections from termination without notice, cause, or completion of care.²⁹ These ethics apply regardless if the patient is a former enemy combatant or whether they are practicing in a hostile situation, such as a prison’s medical center or with detainees subjected to improper treatments. As Dr. Steven H. Miles examines in his book regarding medical ethics with detainees: “Medical ethics and international codes of conduct oblige [medical professionals] to prevent and disclose torture.”³⁰ Thus, in addition to moral ethics, doctors, like lawyers, are subject to professional ethics. These ethics include assessing the medical situation of their patient and treating in a way that ultimately does ‘no harm’ to the patients. This duty to their patients should come before their roles as a soldier, military

²⁶ Achuthan (on behalf of Aleke Banda) v. Malawi, African Comm’n on Human & Peoples’ Rights, 8th Annual Activity Report, Comm’n No. 64/92, ¶ 7 (1995), available at <http://www1.umn.edu/humanrts/africa/comcases/64-92b.html>.

²⁷ *Mika Miha v. Equatorial Guinea*, Comm’n No. 414/1990, U.N. Doc. CCPR/C/51/D/414/1990, ¶ 6.4 (U.N. Human Rights Comm. 1994), available at <http://www1.umn.edu/humanrts/undocs/html/vws414.htm>.

²⁸ See *Greek Medicine*, *supra* note 1.

²⁹ CODE OF MEDICAL ETHICS, *supra* note 18 (referencing Opinion 10.10: Fundamental Elements of the Patient-Physician Relationship, which include confidentiality, continuity of treatment, and other duties and obligations).

³⁰ MILES, *supra* note 24.

doctor, or any other role they may be fulfilling.³¹

2.4. Recent Example of Refusing to Provide Care

A recent example out of Libya serves as a model where doctors decided that they upheld their medical ethics by refusing to provide care to detainees subjected to torture. In July 2013, Doctors Without Borders (or Médecins Sans Frontières) (“DWB/MSF”) refused to continue to treat victims of interrogations and torture because of their repeated injuries from abuse.³² Patients were brought to prison doctors and medical professionals between interrogations for medical treatment so that the detainees could heal from the wounds they sustained during beatings and torture, only to return to the interrogation centers to withstand further brutal interrogations.³³ The doctors and medical professionals stated their role is to “provide medical care to war casualties and sick detainees, not to repeatedly treat the same patients between torture sessions.”³⁴ Both officially recognized military and security bodies carried out these interrogations, as well as by a number of armed militias operating outside any legal framework.³⁵ The group of doctors treated 115 detainees in total³⁶

³¹ George J. Annas, *Military Medical Ethics – Physicians First, Last, Always*, 359 *NEW ENG. J. MED.* 1087, 1087-90 (2008) (arguing that physicians should remember, especially in the face of human rights violations like torture, not only that they are physicians “first” but that they are also physicians “last and always”).

³² Press Release, Doctors Without Borders, Libya: Detainees Tortured and Denied Medical Care (Jan. 26, 2012), available at <http://www.doctorswithoutborders.org/news-stories/press-release/libya-detainees-tortured-and-denied-medical-care>.

³³ *Id.* See also MSNBC.com News Services, *Medical Group Refuses to Treat Libya Prisoners ‘Between Torture Sessions,’* NBCNEWS.COM (Jan. 26, 2012, 2:04 PM), http://worldnews.nbcnews.com/_news/2012/01/26/10245098-medical-group-refuses-to-treat-libya-prisoners-between-torture-sessions (providing additional reporting on the DWB/MSF decision to withdraw from providing care in Libya).

³⁴ Press Release, Doctors Without Borders, *supra* note 32 (quoting DWB/MSF General Director Christopher Stokes).

³⁵ See *id.* (stating that notification letters were sent to “the Misrata Military Council, the Misrata Security Committee, the National Army Security Service, and the Misrata Local Civil Council”). See also MSNBC.com News Services, *supra* note 33 (noting the torture was carried out by “officially recognized military and security bodies as well as by a number of armed militias operating outside any legal framework”).

³⁶ Press Release, Doctors Without Borders, *supra* note 32.

for torture related injuries, including a group of nine detainees after the doctors sent notification letters.³⁷ The doctors identified numerous injuries and obvious signs of torture, including two deaths.³⁸ Before refusing to provide care, the doctors notified the National Army Security Service that a number of patients needed to be transferred to hospitals for urgent and specialized care.³⁹ However, these patients were taken back to interrogation centers.⁴⁰ Thus, even after notifying the offending bodies and stating that the doctors would have to refuse to provide medical care, the doctors continued to receive tortured patients.⁴¹ Only after that point did DWB/MSF cut off providing care.⁴²

This example provides a realistic view of what some doctors and medical professionals face, or will have to face, within this realm of practicing medicine. The DWB/MSF example also provides a practical, responsible guide for actions that should be taken when doctors and medical professionals determine, based on their medical and ethical judgment, that providing care is no longer acceptable for these patients. This example shows what refusing care would look like in practice as this comment examines the ethical justification of these actions and proposes a legal framework to support it.

3. ETHICAL EVALUATION OF REFUSING TO PROVIDE CARE

3.1. *Ethical Analysis*

Physicians and medical professionals are justified in refusing to provide care to detainees under certain conditions because their actions, if performed with a permissible intention, ultimately fulfill

³⁷ *Id.* (“The most alarming case [was] when MSF doctors treated a group of 14 detainees who returned to a detention facility from an interrogation center. Despite previous MSF demands for the immediate end of torture, 9 of the 14 detainees had suffered numerous injuries and displayed obvious signs of torture.”).

³⁸ See MSNBC.com News Services, *supra* note 33 (providing additional information regarding the injuries and suspected deaths).

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.* See also Press Release, Doctors Without Borders, *supra* note 32 (referencing receiving nine detainees that were victims of repeated torture).

⁴² *Id.*

their duty to do no harm and end prolonged suffering of their patient. This ethical justification is not based on consequences alone, though doctors and medical professionals must determine whether their actions of treating a detainee will ultimately lead to the continued suffering of that patient. I argue that the intention to minimize harm is required, rather than the consequences alone of refusing care, because the actor must have an ethical state of mind to fulfill their professional and ethical duty to not harm others. Refusing care in these circumstances is also analogous to the medical community's prohibition on participating in the death penalty, specifically in that psychiatrists cannot determine a prisoner's mental fitness for execution.

Doctors and medical professionals must use their trained medical judgment to assess the specific situation that they face, and must ultimately decide that refusing to care for a certain patient is the justified course action. Refusing to provide care is justified because it fulfills the deontological duty to others as well as the professional duty to do no harm. (Though I advocate from a deontological point of view, consequentialists could also find that not providing care is justified in these circumstances because the overall consequences of the action – the reduction of continued pain and suffering of the detainee – increases the good to justify the action.) A duty to others, similar to the duty to 'do no harm,' is a core deontological duty.⁴³ In determining where their duty to others is implicated, the medical professional must consider factors like the extent of the detainee's injuries, the likelihood the injuries will occur again, and other relevant factors. For example, if a detainee is a repeat patient for the same or similar injuries that correlate with circumstances of abusive interrogation or torture, the doctor can likely assume this patient will continue to suffer the same or similar injuries after he recovers with the aid of that doctor.⁴⁴ Once this duty to others is implicated, medical professionals must act to protect and assist the detainee because of their position and ability to provide care. Then, any of the

⁴³ *Kantian Duty Based (Deontological) Ethics*, SEVEN PILLARS INST., <http://sevenpillarsinstitute.org/morality-101/kantian-duty-based-deontological-ethics> (last visited Dec. 18, 2013) (stating Kant's first categorical imperative of "Do not impose on others what you do not wish for yourself" and his second categorical imperative that "a person must maintain her moral duty to seek an end that is equal for all people").

⁴⁴ This determination is much like the one the DWB/MSF physicians made. See Press Release, Doctors Without Borders, *supra* note 32.

doctors' and medical professionals' actions to reduce the pain and suffering endured by this patient are justified, if done with the aim to fulfill this duty to others. These actions may require treating, or they may require refusing to provide care if the physician or nurse determines that their assistance to the patient will only lead to the repeated abuse.

Making the determination not to treat is no easy task. Gray areas will exist that may require additional consideration of other deontological duties and factors based on the facts of each case. However, black and white cases do exist, as demonstrated in the example above with Libya. These clear cases are when the doctors reasonably know that providing treatment will only keep the detainees healthy enough to be subjected to more torture and abusive interrogations. At this point, if the doctor provides immediate treatment, they would contribute to the detainee's long-term pain and suffering because the detainee is now available to endure further torture and other abusive conduct. Here, the doctors and medical professionals become a part of the cycle of torture and abusive interrogations. In these circumstances, the medical professionals involved need to follow their duty to others, refuse to treat the detainee, and cease to assist in the detainee's continued pain and suffering.

3.2. *Intention-Based Model Is Required for Justification*

Having policy and laws that focus on reducing the overall amount of suffering for a detainee seem to satisfy ethics models based on deontological and consequentialist principles. However, I argue that, in these circumstances, an ethics model focused on intentions and duties is best because this model provides important limits on what behavior is ethically justified. Limits come from duties, similar to duties that doctors develop through their responsibilities as members of the medical community. These duties also promote behavior that is desirable – getting good, unbiased treatment decisions – rather than decisions based on outcomes that could also satisfy other 'bad' motivations, such as being primarily motivated by a dislike for what the detainee believes or supports.

G. E. M. Anscombe advocates for an intention-based model,

especially as it applies to war.⁴⁵ Anscombe makes this distinction because she finds that the morality of decisions is based in the intentions of the actor,⁴⁶ not in the culpability of the opposing actor⁴⁷ or total utility of a situation.⁴⁸ These intentions matter because they are linked to the duties and absolute prohibitions – duty to others, duty to not kill, etc. – that one must follow as moral actors.⁴⁹ Thus, the intent to act in accordance with duties – both that are innate and those that apply as a professional – should be the measure of whether an act is justified or not, and not what happens after the act.⁵⁰ This focus on intent to comply with duties and prohibitions is also what places the limit on conduct that Anscombe discusses. These duties and absolute prohibitions provide the clear-cut impermissible cases so that the doctrine of double effect is not taken to its extreme.⁵¹ Though, her distinction still allows for actions with ‘bad’ consequences, such as death of the detainee from lack of care, because the actor was ultimately attempting to act morally within the permissible bounds of her duties and prohibitions.⁵²

Take the hypothetical case that is modeled off what was seen in Guantanamo.⁵³ A detainee is brought to the prison hospital, showing signs of repeated beating, food deprivation, and exhaustion. He also exhibits symptoms of diabetic shock resulting from the conditions that he endured. One doctor assesses that he has seen this patient before many times, and previously notified

⁴⁵ G. E. M. Anscombe, *War and Murder*, in *NUCLEAR WEAPONS: A CATHOLIC RESPONSE* 45 (Walter Stein ed., 1961).

⁴⁶ *Id.*

⁴⁷ See JEFF MCMAHAN, *KILLING IN WAR* (2009) (advocating for a model where the culpability of the actor is determinative).

⁴⁸ Utility of a situation, or utilitarianism, is similar to Consequentialism, both of which are seen as opposing theories to deontological/duty-based ethical models.

⁴⁹ Anscombe, *supra* note 45.

⁵⁰ *Id.*

⁵¹ Anscombe includes a very good analysis of the limits of ‘intention’ to avoid taking the doctrine of double effect too far to essentially render ‘intention’ meaningless. *See id.*

⁵² *See id.* (providing the example of self-defense when one is intending to “ward off an attack” not intending to kill someone).

⁵³ Sharrock, *supra* note 14 (detailing a story out of Guantanamo where a medic wanted to treat detainee for diabetic shock, but was ridiculed and ignored by higher-ups, colleagues, and soldiers, so care was not rendered. The detainee ended up dying from lack of treatment, though he did not suffer further abusive interrogation).

his superiors and other officials of the patient's condition and general concerns regarding his condition. The doctor ultimately makes a judgment not to treat the patient because the doctor reasonably believes that if he treats the patient today, he will only continue to see this patient after future torture sessions. Another doctor in the hospital encounters the same patient, but refuses to treat because she does not approve of this patient's extreme beliefs and knows what will reasonably result from not treating. Because of the lack of treatment, the detainee dies of diabetic shock. In both of these cases, where one doctor decides not to treat to cause the least amount of harm and the other doctor chooses not to treat because she does not value the detainee, the harm avoided – prolonged suffering from being subjected to aggressive interrogations – is the same. Yet, Anscombe would find these cases are different moral situations where the first case is justifiable and the second is not based on the intent of the doctor.

Anscombe finds a moral distinction between the first doctor's action that merely *foresees* (not treating a patient) a bad consequence (patient dies) and that same action from the second doctor that *intends* (not treating a patient) the bad consequence (patient dies). Part of this distinction is because the first doctor is not attempting to bring about the bad consequence, but rather something else: minimizing the pain and suffering of the patient. Anscombe does caution against using this logic to its extreme where it becomes dangerous⁵⁴ – i.e. the second doctor incorrectly rationalizing, 'I didn't intend to let the patient die, I simply intended to not to provide care, thus it's permissible.' Anscombe recognizes that, when taken to the extreme, the doctrine of double effect can justify anything from the actor's point of view.⁵⁵ Thus, when applied correctly, the intention-based rationale is the most appropriate here because only doctors who exercise their proper medical judgment should be justified in their actions, not those trying to achieve other ill-intended results under the veil of treatment. In other words, for this hypothetical example, intending the patient's death is different from foreseeing that death

⁵⁴ Anscombe, *supra* note 45 (cautioning against mistaking what one actually intends and what one attempts to say they 'intend' to merely justify their action, essentially expressing the limits of the doctrine of double effect).

⁵⁵ *Id.* ("It is nonsense to pretend that you do not intend to do what is the means you take to your chosen end. Otherwise there is absolutely no substance to the [Christian] teaching that we may not do evil that good may come."). *Id.* at 59.

when refusing to provide care because these two acts can be distinguished between the 'wanting' of something to happen (second doctor) and the 'predicting' something will happen (first doctor). Doctors 'wanting' the bad consequence by not treating are not justified in their actions. The doctor who can predict a death while refusing to provide care for the patient's overall well-being is the one executing a justified act. Again, having a 'good motive' while foreseeing a bad consequence still lends to an ethically justified act.

3.3. *The Medical Ethics Analogy of Treating on Death Row*

The medical community's refusal to participate in the death penalty provides a strong analogy to the policy, reasoning, and ethics of refusing to provide care to those subjected to repeated torture. The medical community has "longstanding and absolute prohibition" of participating in lethal injection executions.⁵⁶ Because the Eighth Amendment bans the execution of the mentally incompetent,⁵⁷ this prohibition in the United States includes banning psychiatrists from declaring a death row inmate mentally competent for execution.⁵⁸ The medical community finds that engaging in such behavior violates the core medical ethics, and this prohibition is balanced against the State's desire to inflict punishment, much like the national security goals that medical practitioners face during a time of war.⁵⁹ The American Medication Association's (AMA) prohibition rationalizes that

⁵⁶ Lawrence Nelson & Brandon Ashby, *Rethinking the Ethics of Physician Participation in Lethal Injection Execution*, 41 HASTINGS CTR. REP. 28 (2011).

⁵⁷ *Ford v. Wainwright*, 477 U.S. 339 (1986) (holding that executing those inmates that are not mentally competent is cruel and unusual punishment and unconstitutional under the eighth amendment).

⁵⁸ See Alfred M. Freedman & Abraham L. Halpern, *A Crisis in the Ethical and Moral Behavior of Psychiatrists*, 11 CURRENT OPINION IN PSYCHIATRY 1, 2 (1998), available at http://www.wpanet.org/uploads/Publications/WPA_Books/Additional_Publications/WPA_Forums_on_Current_Opinion/psychiatrists-death-penalty.pdf (debating the purpose and ban on psychiatric evaluations of competence to be executed).

⁵⁹ See *id.* ("Psychiatrists today are indeed torn between traditional ethical principles and strong pressures from society, particularly certain segments of the legal profession, to make compromises and become collaborators in the demands of the law.").

“[p]hysician participation in executions contradicts the dictates of the medical profession by causing harm rather than alleviating pain and suffering.”⁶⁰ The World Psychiatric Association Congress unanimously agreed that “[u]nder no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competence to be executed.”⁶¹

Refusing to make competency determinations and refusing to provide care for detainees subjected to abusive interrogations and torture are analogous because, in both cases, the physician is not actively participating in the harmful act (administering life ending drugs or torture tactics), but their actions directly contribute to the administration of the harmful act. A death row prisoner cannot receive a lethal injection unless a psychiatrist determines they are mentally competent.⁶² Similarly, a detainee that needs treatment after being subjected to abusive interrogations and torture cannot return to their interrogator without receiving treatment. Thus, both of these physicians directly participate to their patient’s cycle of ‘harm.’ Because the medical community agrees that psychiatrists are ethically prohibited from participating in competence evaluations for executions, even though they are not directly administering harm, physicians also cannot ethically treat detainees that will only receive repeated abuses as a result of being treated.

One key reason for prohibiting the participation of psychiatrists in the death penalty is the proximity of the doctor’s action to the execution.⁶³ Drs. Alfred M. Freedman and Abraham L. Halpern state, “The proximity of this participation and the act of killing casts doctors, metaphorically, as hangmen’s accomplices.”⁶⁴ This same proximity is also found in torture. When torture is repeated, a cycle of abuse is formed. This cycle includes medical treatment to keep detainees alive and well enough to sustain the next round of interrogation or torture. The doctors’ participation

⁶⁰ AM. MED. ASS’N, PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT: CEJA REPORT A-I-92, at 365 (1992), available at <http://www.ama-assn.org/resources/doc/code-medical-ethics/206b.pdf>.

⁶¹ See Freedman & Halpern, *supra* note 58, at 1 (examining the ethics of psychiatrists’ participation in the death penalty).

⁶² See *infra* notes 57–58 and accompanying text. *Ford v. Wainwright* also holds that inmates must receive a competency determination upon request. 477 U.S. 399, 430–31 (1986).

⁶³ Freedman & Halpern, *supra* note 58.

⁶⁴ *Id.* at 1.

as a part of the cycle becomes impermissible because the doctors become ethical 'accomplices' to the torturers.

Counter arguments for allowing psychiatrists to participate the death penalty are similar to those that apply to torture: these arguments state that the psychiatrists are providing a dual role for the justice system. In other words, physicians should be acting as something other than 'physicians first.' Thus, these psychiatrists are not subject to traditional medical ethics. Proponents of absolute prohibitions for psychiatrists actually caution against this type of argument because of its implications for physicians in "executions, torture or managed care administration."⁶⁵ This reasoning strips a psychiatrist, or physician, from any medical ethics' limitations and leaves the physician as an unregulated practitioner. This practice also risks losing the trust of the public, or worse "public condemnation."⁶⁶ In addition to the reaction of the public, the medical community makes it clear that declaring prisoners competent for the death penalty is simply participating in unethical behavior. This same rationale and prohibition should apply to medical professionals treating detainees subjected to repeated torture and abuse, and that the risk of placing these doctors in close proximity to the torturers is just too great.

3.4. *Additional Applicable War Conventions: Mixture of Law and Ethics*

War conventions are formed from a combination of culture, legal, ethical, and other priorities from various countries and the international community. This comment already discussed the medical ethics, professional standards, and existing laws that contribute to war conventions surrounding treating, or not treating, in situations of abusive interrogation and torture. Other sources of culture and codes additionally lend themselves to this discussion. Rule of War principles, such as the Principle of Distinction, discussed *supra* in Section 2.1., also provides the necessary understanding that status of the individuals that receive treatment. These principles are important because detainees receive more protections and considerations than enemy

⁶⁵ *Id.* at 1.

⁶⁶ *Id.*

combatants.⁶⁷ Thus, doctors and medical professionals must act with intentions to assist these patients, rather than ignoring or intentionally wanting to cause their immediate suffering, even if they ultimately act in the detainee's best interests overall. According to these international conventions, doctors must care for their patients as 'physicians first,' rather than as a soldier or other role that may place the patient second to other considerations.⁶⁸ Lastly, though these proposed policies require notice requirements, arguably these abuses are *jus cogens* – crimes against humanity – and the offending individuals should know that medical professionals do not provide their services to support torture and abuse. Thus, withdrawing from providing these medical services do not necessarily require notice that is generally required by other medical duties.

In addition to the war conventions, special protections are guaranteed in the physician-patient relationship, such as confidentiality and continuity. In these circumstances, the physician can approach the physician-patient relationship in two ways. First, the doctor can consider that a physician-patient relationship does not exist because the doctor does not intend to treat the detainee, and the doctor has this intent from the beginning. She must act in a way that would not lead a detainee to perceive that he is the doctor's patient. Further, such as the doctors in Libya did, the doctors may remove themselves from the prison hospital, so that they would not be present to even receive the patients. Second, if the doctor decides that a physician-patient relationship does exist between the detainee and doctor, the doctor may decide that refusing to treat is the best course of treatment that the patient should receive. In addition, the doctor may have other issues, such as patient consent, which is raised in Section 5.3.

Patient confidentiality would also be implicated in these circumstances. However, the doctor can keep the patient's identity confidential, especially in regards to military reporting requirements, or, more likely, consider that revealing this information is not a breach of confidentiality because it is used for the protection of other persons from a known risk and because the

⁶⁷ See *supra* Section 2.1.

⁶⁸ See Annas, *supra* note 31 (citing the 'physician first' mantra, but concluding that "'physician first' guidance is only half the story;" though "[b]asic human-rights violations, including torture, inhumane treatment, and experimentation without consent, can never be justified").

information is revealed internally to determine a future course of action or treatment. These additional duties are very important and should be considered in how the medical professionals follow the proposed requirements of this policy, though medical professionals will have to balance these duties with the overall best interests of the patient.

4. LEGAL EVALUATION

Providing care can be considered as violating torture laws and policies because when doctors help keep detainees well enough to participate in abusive interrogations and torture, they are aiding in the cycle of torture. These doctors can be seen as participants in torture, either as complicit to torture or implicated as participants in a conspiracy, much like criminal conspiracy. On the other hand, although refusing to provide care is ethically justified and providing care is illegal, refusing to provide care can also violate some current torture statutes, international laws, and policies. Because detainees are required to receive adequate medical care, one could find that doctors refusing to provide care are in violation of these statutes. To correct this possibility, I propose clear exceptions, along with certain requirements to these policies in Section 5.

4.1. *Violations of Torture Statutes and Criminal Laws*

Complicity to torture is a violation included in many torture law policies. Article 4 of Convention Against Torture (CAT) requires countries to establish crimes for torture, including complicity to torture.⁶⁹ Currently, the United States has established the Torture Victims Protection Act, which established “an unambiguous and modern basis for a cause of action” for torture violations.⁷⁰ Article 3 of UN Resolution 37 also expressly prohibits medical professionals’ participation and complicity in

⁶⁹ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc CAT/C/28/Add.5, art. 4, entered into force Feb. 9, 2000. See also Weissbrodt & Heilman, *supra* note 22, at 353 n.51.

⁷⁰ Torture Victim Protection Act of 1991, Pub. L. 102-256, H.R. 2092, 106 Stat. 73 (1992).

torture.⁷¹ It states, "It is . . . an offence 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."⁷² Thus, if medical professionals do continue to treat patients as a part of a cycle of torture, they could be held liable for directly violating these statutes.

Under the U.S. Model Penal Code (MPC) definitions of conspiracy and complicity, an individual is held criminally liable for crimes that a group of which she is a member commits. These crimes require only belonging to extend this liability.⁷³ With the MPC, the law assumes that even if an individual is not directly participating in the crime, they are nonetheless liable because of their membership and knowledge of what the group plans to commit, finding them implicitly involved.⁷⁴ As discussed *infra* in Section 5.3., rather than helping to prevent abuse, medical professionals' presence during interrogations actually enables improper interrogation tactics.⁷⁵ Criminal Conspiracy, § 5.03 of the MPC, states "[a] person is guilty of conspiracy with another person or persons to commit a crime if with the purpose of . . . facilitating its commission [s]he . . . agrees to aid such other person or persons in the . . . commission of such crime."⁷⁶ For complicity, § 2.06 states "a person is an accomplice of another person in the commission of an offense if . . . with the purpose of . . . facilitating the commission of the offense, [s]he . . . aids . . . such other person in planning or committing it."⁷⁷ Because torture is without argument a crime, doctors and other medical professionals could be considered complicit or co-conspirators to torture in circumstances where medical professionals are aware of abuse and continue to treat the detainees who they know will ultimately endure further torture. The element of 'with the purpose' will most likely relieve most medical professionals from liability because they will not likely have the "conscious object to engage in [torture] or to cause such a

⁷¹ Principles of Medical Ethics, G.A. Res. 37/194, 111th plen. mtg., U.N. Doc. A/Res/37/194 (Dec. 18, 1982).

⁷² *Id.*

⁷³ MODEL PENAL CODE §§ 2.06, 5.03.

⁷⁴ *Id.* (lacking a requirement for actually committing the alleged crime).

⁷⁵ *Infra* notes 82-84.

⁷⁶ MODEL PENAL CODE § 5.03.

⁷⁷ MODEL PENAL CODE § 2.06.

result.”⁷⁸ Doctors in extreme examples of purposefully participating in torture through providing treatment or information to make interrogations more efficient will likely be liable under complicity and conspiracy. This analysis will rely on the true intentions of the medical professionals involved and how much they intended to aid the offending individuals. However, it is worth noting that, even in these extreme situations where doctors actively assisted interrogators in Guantanamo, no cases have ever held a doctor complicit to torture or as a co-conspirator to torture.

4.2. *Distinguishing Between the Gray Areas*

Having physicians in the interrogation room and directly participating in torture by providing medical information is strictly prohibited because the physician carrying out those roles clearly violates medical ethics and abuses their role as a medical professional. These black and white scenarios, as discussed above and as seen in Libya, also exist when providing care to detainees clearly becomes a part of a cycle of torture. On the other side of the spectrum, other circumstances exist where physicians are simply treating detainees for general health care concerns, such as for diabetic shock, and are clearly justified, and required, to treat these patients. However, with much of the legal framework that exists, gray areas occur in the hard cases, but this existence does not foreclose on creating policy for clear situations where refusing to provide care is clearly ethical and legal. Physicians would still have to treat wounds from interrogations upon the first instance when they do not know if the wounds resulted from a cycle of repeated improper interrogation or torture. Upon this first instance, physicians would have to give notice and report such instances, then, if the medical professionals receive the same or similar injuries from the same or different patient, they will have to make a medical determination to refuse care.

⁷⁸ MODEL PENAL CODE § 2.02(2)(a)(i) (stating the definition of “act[ing] purposely”).

5. PROPOSAL FOR POLICY

Laws and policies should protect medical professionals who refuse to provide care to detainees when they determine that the detainees will only endure further abuse if treated. Policies protecting this decision should also be created to ensure safeguards are in place to reduce the risk of abuse. Comprehensive policy should include reporting and notification requirements to best protect the patients, doctors, and offending individuals from the risks of abandoning care without the chance to first correct the abusive behavior. Again, refusing to provide care to detainees will remain an exception to torture policies, not the rule.

5.1. *Providing Exceptions Based on Reasonable Medical Judgment*

The policy proposition is to create an exception to the requirement of providing adequate medical care for detainees. This exception would allow a physician or medical professional to refuse to provide adequate medical care when they know or reasonably believes that a detainee or a group of detainees is being subjected to repeated abuses in interrogation or torture. The physician or medical professional must reasonably know that providing care will lead the detainee to endure continued pain and suffering that results from these abuses. Before the exception can be invoked, the physician must first know or believe that abuses in interrogation or torture occurred and must provide notice, if possible and safe to do so, to the offending individual(s), government(s), or organization(s) that if the abusive behavior do not cease, the physicians or medical professionals will withdraw from providing care. The medical professional must also report the perceived abuse to their medical and military supervisors, if possible and if safe to do so. This report must include important and relevant facts about the detainees, injuries, and other circumstances so that the supervisors are able to assess and provide feedback regarding the refusal of care. Approval from the supervisors is not required.

The standard of 'knowledge' is actual knowledge or reasonably should have known given the experience of the physician. Ignorance is, thus, not an excuse. The physicians working in Libya

made the determination of torture because the wounds on the detainees obviously resulted from beatings and other abuse.⁷⁹ Again, this policy aims at holding liable those physicians who fail to take the proper action, or refused to act, in circumstances of clear torture or abuse. These policy changes are not meant to interfere with the medical autonomy of a physician who must decide, based on their reasonable assessment of a certain circumstance, whether a detainee is a victim of repeated torture or not.

Currently, New York and Massachusetts have state bills pending before their legislatures that address medical professionals facing circumstances of abuse in interrogations.⁸⁰ Massachusetts House Bill 2017/Senate Bill 1011⁸¹ in the 188th Legislature would establish professional sanctions for medical professionals participating in torture and abusive interrogations. The bills also include reporting requirements and protections for medical professionals that “refuse to participate in prohibited acts or who investigate them.”⁸² The New York bill provides similar ‘bright line’ provisions to protect health care professionals actively refusing to participate in the abuses.⁸³ The proponents of these bills find that additional legislation is “vitally important” because it provides state professional sanctions on professional behavior that “violates professional standards;” improves and protects the medical profession’s reputation, domestically and internationally; and promotes human rights.⁸⁴ The Massachusetts bill expressly

⁷⁹ Press Release, Doctors Without Borders, *supra* note 32.

⁸⁰ MA and NY Legislation to Sanction Health Professionals Who Torture, PHYSICIANS FOR HUM. RTS., available at <http://physiciansforhumanrights.org/issues/torture/us-torture/ma-and-ny-anti-torture-legislation.html> (last visited on Dec. 17, 2013).

⁸¹ S. 1011, 188th Leg. (Mass. 2013), available at <https://malegislature.gov/Bills/BillHtml/126793?generalCourtId=11>. These bills have received support from Physicians for Human Rights, Massachusetts Medical Society, and Massachusetts Campaign Against Torture. The similar bill in New York received endorsements from the New York State Nurses Association, “15 leaders in the medical and health fields – including two Nobel Prize winners, former President George H.W. Bush’s White House physician, and New York-based medical school deans and hospital CEOs,” and others. Press Release, *Top Medical Professionals Support NYS Anti-Torture Bill, Nation’s First* (May 25, 2010), available at <http://assembly.state.ny.us/comm/Health/20100526/>.

⁸² MA and NY Legislation to Sanction Health Professionals Who Torture, *supra* note 80.

⁸³ *Id.*

⁸⁴ *Id.*

prohibits a health care professional from “engag[ing], directly or indirectly, in the torture or abusive treatment of a prisoner” and includes the explicit prohibition of “examining, evaluating, or treating a prisoner to certify whether torture or abusive treatment can begin or be resumed.”⁸⁵ These bills serve as good examples for the exceptions that should be made into domestic and international policies.

5.2. *Reporting and Notification Requirements*

When doctors and medical professionals first make the determination that they have received a patient that is being subjected to abusive interrogations or torture, the doctors should continue to treat the detainee. After this initial determination, the doctors and medical professionals must take steps to notify the offending individuals of their concerns by stating that the medical staff will refuse to provide care if such behavior continues. This notice should only be made when providing notice does not risk the safety of the medical professionals.

Reporting requirements refer to the supervising body of medical and/or military professionals to which the doctors and medical professionals are assigned. Physicians and nurses should engage these two lines of control when possible. The supervising medical professionals can assist in making a professional determination of whether the doctors should withdraw from providing care and can serve as a unbiased supporting body that is both patient- and doctor- focused, rather than, for example, serving as a soldier first. The medical community, much like the legal profession, is a self-regulating profession.⁸⁶ Thus, providing notice to another medical professional will assure extra protection against internal discipline and may also provide a ‘safer’ supervising body for reporting because it is comprised of peers. The doctors and physicians should also report to military supervisors that may have more influence and/or control over the offending body. This reporting also provides protections to the doctors by putting the military supervisors on notice of how the medical professionals

⁸⁵ S. 1011, *supra* note 81, §§ 1D(b), 1D(b)(iii).

⁸⁶ See *Our Mission*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/about-ama/our-mission.page>? (last visited Dec. 18, 2013) (detailing guiding principles to improve and monitor the medical profession).

will handle this particular situation in case the military needs to make strategic decisions based on the refusal of treatment or based on the notification that torture is occurring.

Though reporting requires putting supervisors on notice, reporting does not interfere with medical autonomy. Medical professionals can benefit from their supervisors' input, but are not required to follow their proposals if the medics on the ground reasonably determine that refusing treatment is the best course of action. Similar to how the Army Field Manual provides requirements for reporting to the commander,⁸⁷ physicians should follow similar lines of reporting within the military and with the equivalent superior in the medical field. The EU Guidelines Towards Third Countries on Torture also encourages establishing "effective domestic procedures for responding to and investigating complaints and reports of torture."⁸⁸ States should also ensure they currently operate functional venues for receiving and addressing reports of torture that military and medical professionals can access.

Providing notice is equally important to internal reporting because notification could potentially change the offending individuals' or organizations' behavior without having to withdraw care. The ultimate goal of refusing to treat detainees subjected to torture and abuse is to have this behavior to end, so if this behavior can change through the 'threat' of withdrawing from providing care to detainees, without having to do so, that is a major success. In Libya, Doctors Without Borders indeed tried this tactic by providing notice to the organizations that tortured the detainees, but they continued to receive patients exhibiting the same or similar injuries.⁸⁹ Only after giving this notice did the doctors refuse to treat.⁹⁰ Though the doctors were not successful in this example, it is a prime example that notification can and should be executed before withdrawing treatment. Together, notice and reporting provide two venues to alternatively stop abusive interrogations and torture without refusing to provide care for patients that need immediate assistance.

⁸⁷ ARMY FIELD MANUAL, *supra* note 6, at 5-14.

⁸⁸ GUIDELINES TO EU POLICY TOWARDS THIRD COUNTRIES ON TORTURE, *supra* note 11, at 7.

⁸⁹ Press Release, Doctors Without Borders, *supra* note 32.

⁹⁰ *Id.*

5.3. Counter Arguments and Concerns

Risks to the medical profession, outside of ethics, are also present and generally raised in opposition to restricting the medical profession in a time of war. Some argue that the presence of medical professionals in interrogations will limit what military and other actors do in these interrogations. However, The Constitution Project's Report on Guantanamo reports that the presence of medical professionals provided an implicit authorization to the interrogators behaviors.⁹¹ These individuals would think, 'If it gets too bad, the doctors will stop it' while the doctors did not have any authorization and were not empowered to make such interventions.⁹² As former military medic and psychiatrist, Dr. Robert Jay Lifton, explained, "[A medical professional's presence] can confer an aura of legitimacy and can even create an illusion of therapy and healing" when that environment did not exist.⁹³ Thus, this logic not only proved to be false, but it actually worked counter to its desired result. By providing policies that give medical professionals the authorization to refuse to provide care in certain circumstances, the doctors and medical professionals can better protect patients as well as provide better support and guidance for the military to comply with interrogation procedures.

Another risk that comes into play with physicians and nurses refusing to provide care is the damage to trust of the medical profession. However, this risk to trust must also be understood against its alternative action, which is treating patients to make them healthy enough to endure repeated aggressive interrogations and/or torture. This risk of perceived compliance to torture also comes with risks to the medical community that is addressed within the community, including recent conferences.⁹⁴ This

⁹¹ THE CONSTITUTION PROJECT, *supra* note 18, at 30–31.

⁹² Sharrock, *supra* note 14 (providing a story from a Guantanamo medic, Andrew Duffy, that quoted him as saying, "If a medic was around, there was a sense of some control The guards probably thought, 'If I really cross the line, this guy would stop me.'").

⁹³ Robert J. Lifton, *Doctors and Torture*, 351 NEW ENG. J. MED. 415 (2004), available at <http://www.nejm.org/doi/full/10.1056/NEJMp048065>.

⁹⁴ See, e.g., The Constitution Project & Global Lawyers and Physicians, *Post-Conference Summary: Medical Care and Medical Ethics at Guantánamo*, Washington, D.C. (Dec. 2, 2013) (discussing bioethical issues raised in Guantanamo, such as "impact of health professionals' involvement in interrogations on detainees' trust

perceived participation in improper interrogations also places the offending country in weak position to regulate the international community and other individual countries that also involve the medical community in such behavior.⁹⁵ It “damage[s] the moral standing of [these] doctors,” including American doctors.⁹⁶ Dr. Steven Miles states that after the Bush Administration, the United States is “now in an extremely poor position to protest abuse in other countries.”⁹⁷ He also warns, “It will silence us as a medical community.”⁹⁸ This distrust and ‘silencing’ is analogous to the distrust that the U.S. death penalty created for European doctors.⁹⁹ To protect the status of medical professionals that chose to participate in the international medical community and the public’s trust in its doctors, these provisions that will allow and empower doctors to refuse to provide care to detainees should be developed.

Most doctors and medical professionals would not argue that refusing to treat detainees subjected to repeat torture is unethical, much like most of the medical community do not refute that psychiatrists cannot ethically find a patient competent for execution. Dr. Chiara Lepora, M.D, the current program manager for Doctors Without Borders, and former Bioethics Fellow at the National Institutes for Health (NIH), and Dr. Joseph Millum, Ph.D and staff scientist in the Clinical Center Department of Bioethics and Fogarty International Center at the NIH, argue that, though treating detainees may constitute complicity in torture, this

in military physicians”).

⁹⁵ See Sharrock, *supra* note 14 (reporting bioethicist Dr. Steven Miles’s concerns).

⁹⁶ *Id.* (referring to comments made by AMA critics who believe even putting new standards in place will not correct the damage that this past behavior has caused).

⁹⁷ *Id.* Though this statement was made before the 2014 Senate report on the CIA’s detention and interrogation program, one would assume this sentiment also applies to the Obama Administration. 2014 SENATE CIA REPORT, *supra* note 16.

⁹⁸ *Id.*

⁹⁹ See John Gunn et al., *Comments to Forum on Psychiatrists and the Death Penalty: Some Ethical Dilemmas*, 11 CURRENT OPINION IN PSYCHIATRY 3 (1998), available

at http://www.wpanet.org/uploads/Publications/WPA_Books/Additional_Publications/WPA_Forums_on_Current_Opinion/psychiatrists-death-penalty.pdf (“In [light of the U.S. constitution,] it is difficult for European people, who have (with the notable exception of some countries of the old USSR) effectively given up the death penalty, to understand why a civilised nation indulges in the ritualised cold-blooded killing of individuals . . .”).

determination does not constitute an absolute prohibition.¹⁰⁰ Rather, Lepora and Millum state that doctors must consider multiple factors before refusing to treat, and can still be justified in treating, even when it amounts to complicity to torture (if then minimized).¹⁰¹ These factors include:

First, doctors should assess the consequences of the different options open to them, including not only consequences for themselves and for the patient, but also the possible wider social effects, such as encouraging or discouraging policies that permit torture. Second, doctors should attempt to discern and follow the requests of the patient regarding his or her care. Finally, doctors should weigh the degree to which the act would be complicit in torture.¹⁰²

Though Lepora and Millum raise factors that should be included in the physician's initial determination that she has a duty to the detainee not to treat him, Lepora and Millum focus largely on consequences of the actions of refusing to treat. The medical professional involved should consider the consequences of not treating, but these consequences should remain patient-focused, as is the doctor's duty, and only to the extent that the consequences trigger the medical professional's duty to refuse to treat. By focusing on duties, the doctor is more likely to act in consideration of their intentions and can focus on the more immediate pattern of abuse, rather than hypothesizing about an unreliable, 'ultimate' consequence for the patient and other social considerations. Lepora and Millum also consider if the offending individuals (i.e. the torturers) want that the detainee receives treatment. The offending individuals' desire to have the detainee treated is only relevant when it indicates whether torture will occur again. If a doctor finds that the interrogator's expression of concern regarding treatment is not indicative of whether they will torture a detainee, then the doctor should not consider it. Though this argument is overall consequentialist rather than intention and

¹⁰⁰ Lepora & Millum, *supra* note 2, at 38 ("[S]ometimes the right thing for a doctor to do, overall, is to be complicit in torture.").

¹⁰¹ *Id.* at 39.

¹⁰² *Id.*

duty focused, this argument includes consideration for patient's wishes and advocates for receiving informed consent. To the extent possible, a patient's desire to receive treatment, even if they may be subjected to further torture, may factor into a medical professional's determination of overall harm suffered by the patient. This consideration of the patient's wishes in the face of repeated torture must reach standards of informed consent to receive care, i.e. not from duress and from a full understanding of the future pain and suffering, and be a part of a reasonable medical decision.

Another counterargument is that policies permitting the refusal of providing treatment are subject to abuse because, though the medical profession is self-regulating, the community has not disciplined doctors who participate in improper interrogations or torture. One news report stated that "even as the nation debates disbarment for the Bush administration lawyers who green-lighted torture, the medical profession has dealt reluctantly, if at all, with its own involvement."¹⁰³ This lack of discipline is especially found when government officials or state policy provides for such tactics. Retired Army General Dr. Stephen N. Xenakis, M.D., who is described as a "rare outspoken critic among military doctors," stated, "'The indifference [of the medical community] is shocking."¹⁰⁴ Most doctors and medical professionals treat based on codes and can only reach those who are subject to these codes. Providing policies, much like those proposed in New York and Massachusetts, that require internal reporting to other medical professionals and the use of professional medical judgment can empower doctors to use their discretion based on what they observe, rather than military protocol. The internal reporting can also strengthen how strictly doctors are held responsible for these actions. Reporting requirements also assist with limiting abuses because it involves supervising medical professionals at an earlier point in the decision to treat, or not treat, than policy currently requires. Because of this early intervention, reports regarding the reasonableness of the reporting physician are taken, which can be used for assessing whether discipline is required. For example, if a supervising physician expresses serious concern about the reporting physician's assessment of the situation in the field, then

¹⁰³ Sharrock, *supra* note 14.

¹⁰⁴ *Id.*

the disciplinary committee knows that the reporting physician was put on notice that her medical judgment was not reasonable, supporting disciplinary action. Again, these situations are for those clearly in violation of medical and moral ethics where even a physician looking at a cold report could make a decision one way, rather than the close cases that depend more on the facts of the case. However, concerns of abuse do not rise out of these 'gray' cases, but rather out of cases that clearly require the refusal of treatment. In addition, clearer and more pragmatic definitions of what is permissible may empower disciplinary board and assist courts in taking more action because abuses are more identifiable.

6. CONCLUSION

Doctors and medical professionals are legally and ethically required to refuse care in certain circumstances when treating subjects of interrogations. At a certain point, doctors and medical professionals obey the Hippocratic Oath by refusing to provide medical care to those subjected to repeated improper interrogations and torture. These professionals must use their reasonable judgment based on their medical training and knowledge of the immediate situation to reach a determination that providing care will only make the injured individual a victim to further, ongoing torture. Along with this judgment, medical professionals must properly report such abuses, and adequately notify the offending individuals or organizations that they will have to refuse further care if the abusive interrogations do not end.

The international community and individual States, including the United States, must provide adequate policies and practices to allow medical professionals to make this judgment. These policies and laws include providing protection from legal and professional consequences under torture statutes and other law. In these circumstances, 'do no harm' is not requiring 'do nothing' but rather empowers doctors to refuse to participate in torture and work towards its end through putting the international community on notice.