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ASSOCIATION

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BOARD OF DIRECTORS **ACTION**
February 16 & 17, 2005
Agenda Item No.

IV. BOARD OF DIRECTORS

Task Force to Explore the Ethical Aspects of Psychologists' Involvement and the Use of Psychology in National Security-Related Investigations

Issue

The Board is asked to allocate $12,500 to support one meeting of a task force to explore the ethical aspects of psychologists' involvement and the use of psychology in national security-related investigations.

Background

Recent events in the United States and around the world, most notably the terrorist attacks of September 11, and the Abu Ghraib prison and Guantanamo Bay detention center situations, have raised questions concerning the use of psychology and the role of psychologists in national security-related investigations and research. The ethical aspects of psychologists' work in these arenas are non-trivial and complex.

Article I of APA's Bylaws states that "the American Psychological Association shall... advance psychology as a science and profession and as a means of promoting health, education and human welfare...by the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association."

The APA Code of Ethics, like many laws and regulations governing the practice of psychology, as well as the ethics codes of other major mental health organizations, have developed largely within specific contexts, that of traditional forms of therapy, academic research, and training programs. As a consequence, such texts may not provide as much guidance as ideal in addressing situations that involve values fundamental to the profession—confidentiality, safety, respect for autonomy, honesty, integrity—in contexts where national security and innocent lives are potentially at issue. This task force will examine the ethical dimensions of psychology's involvement and the use of psychology in national security-related investigations. The overarching purpose of the task force will be to examine whether our current Ethics Code adequately addresses such activities, whether the APA provides adequate ethical guidance to psychologists involved in these endeavors, and whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

In examining these issues, the task force will address issues such as:

- What appropriate limits does the principle "Do no harm" place on psychologists' involvement in investigations related to national security?
- To the extent it can be determined, given the classified nature of many of these activities: What roles are psychologists asked to take in investigations related to national security?
- What are criteria to differentiate ethically appropriate from ethically inappropriate roles that psychologists may take?
- How is psychology likely to be used in investigations related to national security?
- What role does informed consent have in investigations related to national security?
- What does current research tell us about the efficacy and effectiveness of various investigative techniques?
- Would the efficacy and effectiveness of various investigative techniques, if demonstrated, affect our ethics?
- Has APA responded strongly enough to media accounts of activities that have occurred at Abu Ghraib and Guantanamo Bay?

List of Readings
APA Task Force on Ethics and National Security

Tab 1: **Code of Ethics of the American Anthropological Association (1998)**
American Anthropological Association

Tab 2: **Declaration of Professional Responsibility: Medicine's Social Contract With Humanity (2001)**
American Medical Association House of Delegates

Tab 3: **American Psychological Association Resolution Against Torture (1986)**
American Psychological Association Council of Representatives
Against Torture: Joint Resolution of the American Psychiatric Association and the American Psychological Association (1985)
American Psychiatric Association and American Psychological Association

Tab 4: **Ethical Principles of Psychologists and Code of Conduct (2002)**
American Psychological Association

Tab 5: **Relationship Between States, Provinces, and Territories and the APA Ethics Code (2005)**
American Psychological Association Ethics Office

Tab 6: **Ethics in Evolution: The Incompatibility of Clinical and Forensic Functions (*The American Journal of Psychiatry,* 1997)**
P. S. Appelbaum

Tab 7: **A Theory of Ethics for Forensic Psychiatry (*Journal of the American Academy of Psychiatry and Law,* 1997)**
P. S. Appelbaum

Tab 8: **Doctor's Orders—Spill Your Guts (*Los Angeles Times,* 2005)**
M. G. Bloche and J. H. Marks

Tab 9: **Triage at Abu Ghraib (*The New York Times,* 2005)**
M. G. Bloche and J. H. Marks

Tab 10: **When Doctors Go to War (*New England Journal of Medicine,* 2005)**
M. G. Bloche and J. H. Marks

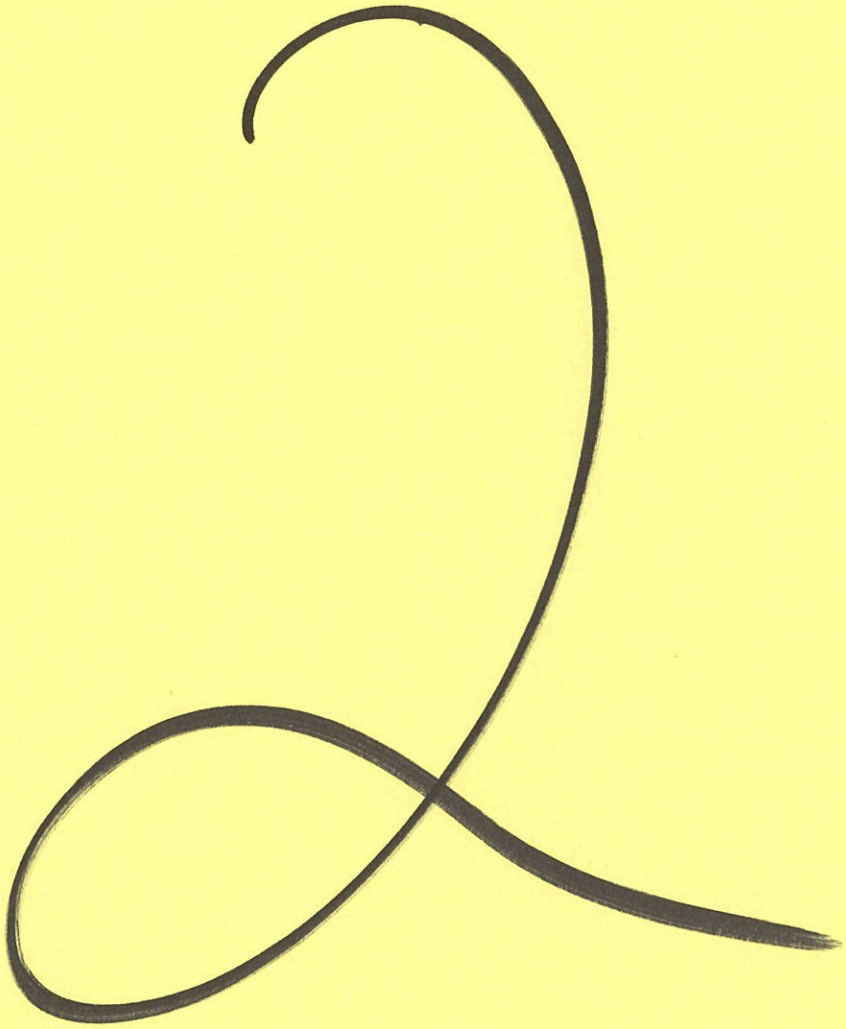
Tab 11: **Ethical Concerns in Forensic Consultation Regarding National Safety and Security (*Journal of Threat Assessment,* 2003)**
C. P. Ewing and M.G. Gelles

Articles With Responses

Tab 48: **Is it Ethical for Psychiatrists to Participate in Competency-to-Be-Executed Evaluations? [Point]** (*Psychiatric Times,* 1998)
P. S. Appelbaum
Is it Ethical for Psychiatrists to Participate in Competency-to-Be-Executed Evaluations? [Counterpoint] (*Psychiatric Times,* 1998)
L. Hartmann

Tab 49: **The Foreign Intelligence Surveillance Act: Law Enforcement's Secret Weapon** (*Journal of the American Academy of Psychiatry and Law,* 2000)
L. Danoff
The Ethical Use of Psychology in Criminal Investigations (*Journal of the American Academy of Psychiatry and Law,* 2001)
J. R. Schafer
Reply to Schafer: Defending the Facts (*Journal of the American Academy of Psychiatry and Law,* 2001)
L. Danoff
Reply to Schafer: Exploitation of Criminal Suspects by Mental Health Professionals is Unethical (*Journal of the American Academy of Psychiatry and Law,* 2001)
J. S. Janofsky
Reply to Schafer: Ethics and State Extremism in Defense of Liberty (*Journal of the American Academy of Psychiatry and Law,* 2001)
P. J. Candilis
Reply to Schafer: Doing Harm Ethically (*Journal of the American Academy of Psychiatry and Law,* 2001)
T. Grisso

Tab 50: **Bibliography for the APA Task Force on Ethics and National Security**
APA Ethics Office



Code of Ethics
of the American Anthropological Association

Approved June 1998

I. Preamble

Anthropological researchers, teachers and practitioners are members of many different communities, each with its own moral rules or codes of ethics. Anthropologists have moral obligations as members of other groups, such as the family, religion, and community, as well as the profession. They also have obligations to the scholarly discipline, to the wider society and culture, and to the human species, other species, and the environment. Furthermore, fieldworkers may develop close relationships with persons or animals with whom they work, generating an additional level of ethical considerations

In a field of such complex involvements and obligations, it is inevitable that misunderstandings, conflicts, and the need to make choices among apparently incompatible values will arise. Anthropologists are responsible for grappling with such difficulties and struggling to resolve them in ways compatible with the principles stated here. The purpose of this Code is to foster discussion and education. The American Anthropological Association (AAA) does not adjudicate claims for unethical behavior.

The principles and guidelines in this Code provide the anthropologist with tools to engage in developing and maintaining an ethical framework for all anthropological work.

II. Introduction

Anthropology is a multidisciplinary field of science and scholarship, which includes the study of all aspects of humankind--archaeological, biological, linguistic and sociocultural. Anthropology has roots in the natural and social sciences and in the humanities, ranging in approach from basic to applied research and to scholarly interpretation.

As the principal organization representing the breadth of anthropology, the American Anthropological Association (AAA) starts from the position that generating and appropriately utilizing knowledge (i.e., publishing, teaching, developing programs, and informing policy) of the peoples of the world, past and present, is a worthy goal; that the generation of anthropological knowledge is a dynamic process using many different and ever-evolving approaches; and that for moral and practical reasons, the generation and utilization of knowledge should be achieved in an ethical manner.

The mission of American Anthropological Association is to advance all aspects of anthropological research and to foster dissemination of anthropological knowledge through publications, teaching, public education, and application. An important part of that mission is to help educate AAA members about ethical obligations and challenges involved in the generation, dissemination, and utilization of anthropological knowledge.

The purpose of this Code is to provide AAA members and other interested persons with guidelines for making ethical choices in the conduct of their anthropological work. Because anthropologists can find themselves in complex situations and subject to more than one code of ethics, the AAA Code of Ethics provides a framework, not an ironclad formula, for making decisions.

Persons using the Code as a guideline for making ethical choices or for teaching are encouraged to seek out illustrative examples and appropriate case studies to enrich their knowledge base.

3. Anthropological researchers must determine in advance whether their hosts/providers of information wish to remain anonymous or receive recognition, and make every effort to comply with those wishes. Researchers must present to their research participants the possible impacts of the choices, and make clear that despite their best efforts, anonymity may be compromised or recognition fail to materialize.

4. Anthropological researchers should obtain in advance the informed consent of persons being studied, providing information, owning or controlling access to material being studied, or otherwise identified as having interests which might be impacted by the research. It is understood that the degree and breadth of informed consent required will depend on the nature of the project and may be affected by requirements of other codes, laws, and ethics of the country or community in which the research is pursued. Further, it is understood that the informed consent process is dynamic and continuous; the process should be initiated in the project design and continue through implementation by way of dialogue and negotiation with those studied. Researchers are responsible for identifying and complying with the various informed consent codes, laws and regulations affecting their projects. Informed consent, for the purposes of this code, does not necessarily imply or require a particular written or signed form. It is the quality of the consent, not the format, that is relevant.

5. Anthropological researchers who have developed close and enduring relationships (i.e., covenantal relationships) with either individual persons providing information or with hosts must adhere to the obligations of openness and informed consent, while carefully and respectfully negotiating the limits of the relationship.

6. While anthropologists may gain personally from their work, they must not exploit individuals, groups, animals, or cultural or biological materials. They should recognize their debt to the societies in which they work and their obligation to reciprocate with people studied in appropriate ways.

B. Responsibility to scholarship and science

1. Anthropological researchers must expect to encounter ethical dilemmas at every stage of their work, and must make good-faith efforts to identify potential ethical claims and conflicts in advance when preparing proposals and as projects proceed. A section raising and responding to potential ethical issues should be part of every research proposal.

2. Anthropological researchers bear responsibility for the integrity and reputation of their discipline, of scholarship, and of science. Thus, anthropological researchers are subject to the general moral rules of scientific and scholarly conduct: they should not deceive or knowingly misrepresent (i.e., fabricate evidence, falsify, plagiarize), or attempt to prevent reporting of misconduct, or obstruct the scientific/scholarly research of others.

3. Anthropological researchers should do all they can to preserve opportunities for future fieldworkers to follow them to the field.

4. Anthropological researchers should utilize the results of their work in an appropriate fashion, and whenever possible disseminate their findings to the scientific and scholarly community.

5. Anthropological researchers should seriously consider all reasonable requests for access to their data and other research materials for purposes of research. They should also make every effort to insure preservation of their fieldwork data for use by posterity.

V. Application

1. The same ethical guidelines apply to all anthropological work. That is, in both proposing and carrying out research, anthropologists must be open with funders, colleagues, persons studied or providing information, and relevant parties affected by the work about the purpose(s), potential impacts, and source(s) of support for the work. Applied anthropologists must intend and expect to utilize the results of their work appropriately (i.e., publication, teaching, program and policy development) within a reasonable time. In situations in which anthropological knowledge is applied, anthropologists bear the same responsibility to be open and candid about their skills and intentions, and monitor the effects of their work on all persons affected. Anthropologists may be involved in many types of work, frequently affecting individuals and groups with diverse and sometimes conflicting interests. The individual anthropologist must make carefully considered ethical choices and be prepared to make clear the assumptions, facts and issues on which those choices are based.

2. In all dealings with employers, persons hired to pursue anthropological research or apply anthropological knowledge should be honest about their qualifications, capabilities, and aims. Prior to making any professional commitments, they must review the purposes of prospective employers, taking into consideration the employer's past activities and future goals. In working for governmental agencies or private businesses, they should be especially careful not to promise or imply acceptance of conditions contrary to professional ethics or competing commitments.

3. Applied anthropologists, as any anthropologist, should be alert to the danger of compromising anthropological ethics as a condition for engaging in research or practice. They should also be alert to proper demands of hospitality, good citizenship and guest status. Proactive contribution and leadership in shaping public or private sector actions and policies may be as ethically justifiable as inaction, detachment, or noncooperation, depending on circumstances.

VI. Epilogue

Anthropological research, teaching, and application, like any human actions, pose choices for which anthropologists individually and collectively bear ethical responsibility. Since anthropologists are members of a variety of groups and subject to a variety of ethical codes, choices must sometimes be made not only between the varied obligations presented in this code but also between those of this code and those incurred in other statuses or roles. This statement does not dictate choice or propose sanctions. Rather, it is designed to promote discussion and provide general guidelines for ethically responsible decisions.

VII. Acknowledgments

This Code was drafted by the Commission to Review the AAA Statements on Ethics during the period January 1995-March 1997. The Commission members were James Peacock (Chair), Carolyn Fluehr-Lobban, Barbara Frankel, Kathleen Gibson, Janet Levy, and Murray Wax. In addition, the following individuals participated in the Commission meetings: philosopher Bernard Gert, anthropologists Cathleen Crain, Shirley Fiske, David Freyer, Felix Moos, Yolanda Moses, and Niel Tashima; and members of the American Sociological Association Committee on Ethics. Open hearings on the Code were held at the 1995 and 1996 annual meetings of the American Anthropological Association. The Commission solicited comments from all AAA Sections. The first draft of the AAA Code of Ethics was discussed at the May 1995 AAA Section Assembly meeting; the second draft was briefly discussed at the November 1996 meeting of the AAA Section Assembly.

1983 United Nations Convention on the Elimination of All Forms of Discrimination Against Women.
1987 United Nations Convention on the Rights of the Child.
Forthcoming United Nations Declaration on Rights of Indigenous Peoples.

DECLARATION OF PROFESSIONAL RESPONSIBILITY
MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

I. Respect human life and the dignity of every individual.
II. Refrain from supporting or committing crimes against humanity and condemn all such acts.
III. Treat the sick and injured with competence and compassion and without prejudice.
IV. Apply our knowledge and skills when needed, though doing so may put us at risk.
V. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
VI. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
VII. Educate the public and polity about present and future threats to the health of humanity.
VIII. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
IX. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association in San Francisco, California on December 4, 2001

AMERICAN
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Council Policy Manual: P. International Affairs

The APA Policy Manual is a collection of policy actions taken by the APA Council of Representatives. This edition includes actions taken after 1960 and up to but not including August 2001. The texts included in the Manual are the texts of the actual motions passed by Council.

III. HUMAN RIGHTS

1. 1986

WHEREAS, the American psychologists are bound by the Ethical Principles to "respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights and;

WHEREAS, the existence of state-sponsored torture and other cruel, inhuman, or degrading treatment has been documented in many nations around the world and;

WHEREAS, psychological knowledge and techniques may be used to design and carry out torture and;

WHEREAS, torture victims may suffer from long-term, multiple psychological and physical problems,

BE IT RESOLVED, that the American Psychological Association condemns torture wherever it occurs, and

BE IT FURTHER RESOLVED, that the American Psychological Association supports the U.N. Declaration and Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the U.N. Principles of Medical Ethics, as well as the joint congressional Resolution opposing torture that was signed into law by President Reagan on October 4, 1984.

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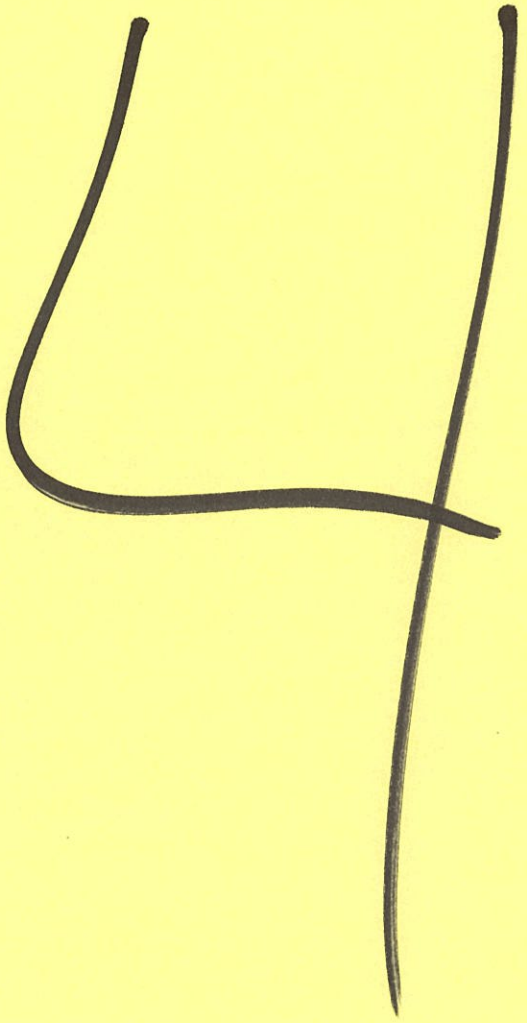

Ethical Principles of Psychologists and Code of Conduct

CONTENTS

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In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take pre-

ing of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations

3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter With Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer–employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation With Other Professionals.)

7. Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is

or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 Informed Consent to Therapy

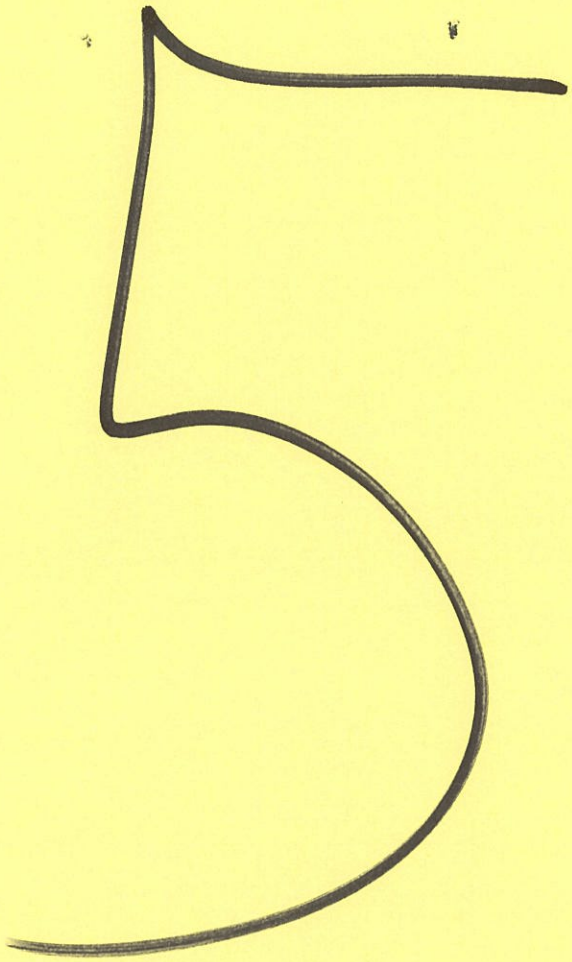
(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the



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Editorial

Ethics in Evolution: The Incompatibility of Clinical and Forensic Functions

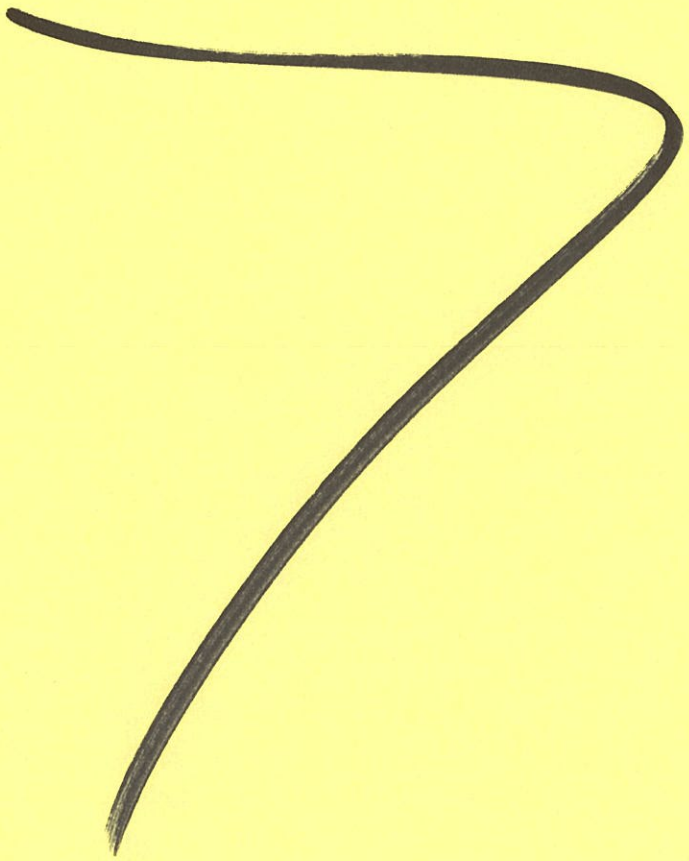
Ethical rules reflect our shared beliefs about which behaviors are laudable and which are to be condemned. As people gain new insights into the nature and implications of their behaviors, ethical codes evolve. In the United States, for example, chattel slavery was common 200 years ago; a century ago, it was still considered acceptable to deny women the right to vote. Both these behaviors are now illegal, but their legal proscription depended on their first coming to be seen as violating ethical norms.

Just as with societal ethics, so for professional ethics. The American Psychiatric Association's *Principles of Medical Ethics, With Annotations Especially Applicable to Psychiatry* (1) now contain injunctions against sexual involvement with trainees and pre-arraignment evaluations of criminal defendants, neither of which were widely endorsed a generation ago. Even before such changes are formally incorporated into a profession's code, it is often possible to track alterations in behavior attributable to an evolving consensus about ethics.

Strasburger and colleagues in this issue of the *Journal* ("On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness") offer a close look at a case in point. When I trained in psychiatry two decades ago, it was unexceptional for psychiatrists—residents included—to be expected to provide forensic testimony regarding persons under their care. Whatever tensions this might have introduced into the treatment relationship were brushed aside as grist for the therapeutic mill. Only in the last decade and a half have prominent concerns been raised regarding the ethics of this practice. Now it is my sense that contemporary sentiment among forensic psychiatrists is accurately reflected in the *Ethical Guidelines for the Practice of Forensic Psychiatry* of the American Academy of Psychiatry and the Law, which discourage psychiatrists from simultaneously performing both clinical and forensic roles (2).

The article by Strasburger et al. points to a number of differences between therapeutic and forensic functions. I want to underscore here a fundamental incompatibility between the ethics of the two situations. Treating clinicians (not just psychotherapists) have primary obligations to advance their patients' interests and avoid causing them harm, reflecting the principles of beneficence and nonmaleficence. In revealing information to treating psychiatrists, patients—except when the physical safety of others is endangered—can be assured that their disclosures will be used by their psychiatrists only to further their interests.

Forensic psychiatrists, however, work in an entirely different ethical framework, one built around the legitimate needs of the justice system (3). Their duties are to seek and reveal the truth, as best they can, whether or not that advances the interests of the evaluee. To be sure, this pursuit of truth is not unbounded; forensic psychiatrists must manifest respect for the persons they evaluate, a principle that excludes, for example, use of deception in the quest for truth. This is why the forensic evaluation



A Theory of Ethics for Forensic Psychiatry

Paul S. Appelbaum, MD

This article offers a justification for a set of principles that constitute the ethical underpinnings of forensic psychiatry. Like professional ethics in general, the principles are based on the particular societal functions performed by forensic psychiatrists and result in the intensification of obligations to promote certain important moral values. For forensic psychiatrists, the primary value of their work is to advance the interests of justice. The two principles on which that effort rests are truth-telling and respect for persons. In the same manner as other physicians who perform functions outside of the usual clinical context (e.g., clinical researchers), forensic psychiatrists cannot simply rely on general medical ethics, embedded as they are in the doctor-patient relationship—which is absent in the forensic setting. Indeed, efforts to retain some residuum of that relationship and its associated ethical principles are likely to create confusion in the minds of both forensic psychiatrists and their evaluees and to heighten the problems of double agency. A virtue of this approach is the clear distinction it offers between clinical and forensic roles.

In 1982, at the annual meeting of the American Academy of Psychiatry and the Law (AAPL), Alan Stone posed a stark challenge to the moral legitimacy of forensic psychiatry.[1] Casting a skeptical eye on the ethical principles forensic psychiatrists might use to guide their behavior, Stone rejected them all. The competing possibilities, he charged, were either internally inconsistent or useless in practice. Indeed, so chaotic was the state of ethics in forensic work that forensic psychiatrists "are without any clear guidelines as to what is proper and ethical."

If correct, as Stone's audience grasped immediately, this conclusion has some fairly troubling implications for forensic psychiatry. A field that is unable to distinguish the proper from the improper, the ethical from the unethical, must tolerate all behaviors equally, since no neutral principle exists for accepting some and condemning others. There can be no good practices and no bad practitioners. The formulation of standards of behavior is beyond the profession's reach. It is difficult to imagine another occupation about

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I propose in this article to develop the outlines of a theory of ethics for forensic psychiatry. It seems inevitable that such a theory will be in some ways incomplete and that adjustment will be required. The likelihood of some degree of imperfection, however, is insufficient reason to avoid beginning the work.

Why "Professional" Ethics?

In attempting to construct an ethical theory for forensic psychiatry, we must confront a basic question about professional ethics in general. Professionals, whether teachers, engineers, accountants, or psychiatrists, are all members of a broader society. If we accept that certain ethical norms are binding on everyone, what justification is there for allowing discrete occupational groups to create separate rules for themselves? To press the point, if the norms embodied in professional ethics are identical to those more widely subscribed to, there would appear to be little reason to construct a distinct ethical framework for the professions. On the other hand, if professional ethics differ from—and therefore have the potential for being in conflict with—general norms, how can we justify such deviations?

To answer this question requires some reflection on the nature and application of moral principles.* Moral philosophers recognize two types of principles that guide our behavior. Bernard Gert calls them "moral rules" and "moral ideals."[13] Moral rules are generalizable maxims that proscribe behavior likely to cause harm to other people. "Thou shalt not kill" is a classic example of a moral rule. We are always obligated to follow a moral rule, unless, as Gert suggests, "an impartial rational person can advocate that violating it be publicly allowed." Thus, a person who deviates from the moral rule against killing in order to save his or her own life would generally be acknowledged as having engaged in a justifiable violation of the rule.

Violations of moral rules, in fact, are an inevitable consequence of the complexity of life. Situations frequently arise in which two moral rules, each seemingly absolute, are in conflict with each other. Resolving that conflict requires balancing, among other morally relevant factors, the nature of each imperative, the benefits and harms likely to flow from its violation, and the alternative means of achieving the desired end. A parent, for example, who bears a moral duty to care for a child, might be justified in breaking a promise to help a friend move her belongings if the child were sick and needed the parent's care. Keeping promises is a moral rule, but in this context, the moral responsibility to care for a child takes precedence.

In contrast to moral rules, moral ideals "encourage people to act so as to prevent and relieve the suffering of others."[13] Although usually worthy of praise, such behavior is not ordinarily required of persons. Were that not the case, people might well feel morally compelled to expend all of their time and resources helping other people, to the utter neglect of their own aims in life. Giving charity embodies a

* Following the practice of most contemporary ethicists, I use the terms "moral" and "ethical" interchangeably in this article.

the work is undertaken correctly, the ethics of any profession differ from ethical standards more generally applied only insofar as is necessary to advance the value in question.[17]

The Necessity for a Distinct Set of Ethics for Forensic Psychiatry

Even with the justification clear in our minds for professional ethics in general, there is an additional obstacle that must be overcome before we can outline the principles of ethics for forensic psychiatry *per se*. It might be objected that a framework to guide the ethical thinking of forensic psychiatrists already exists. Since every forensic psychiatrist is a physician, and the principles of medical ethics are widely subscribed to by members of the profession, the work of elaborating a distinct set of ethical principles for a medical subspecialty is unnecessary. To discern the moral obligations of forensic psychiatrists, or of physicians in any other role, we need only examine the principles of medical ethics.

As a rejoinder to this claim, I note that the assumption that all activities of physicians must be governed by the same ethical principles is clearly fallacious. The ethics of medicine, focused as they are on the principles of beneficence—to do good for one's patients, whenever one can—and nonmaleficence—to avoid doing harm if at all possible—derive from the usual clinical setting.[18] When patients come to physicians for diagnosis and treatment of medical problems, patients seek and are appropriately reassured by physicians' nearly single-minded fidelity to their interests. Fried refers to this as the principle of "personal care."[19] This commitment to personal care has served medicine well, and it constitutes the bedrock on which the structure of medical ethics has been constructed.

Imagine for a moment, however, a physician who selects by chance for his or her patient a medication of uncertain efficacy at a dosage that bears no relation to the patient's own needs, all the while refusing to tell the patient which medication the patient is actually receiving. Indeed, the physician herself remains deliberately ignorant of what the patient is taking, complicating evaluation of the patient's situation, including puzzling changes in the patient's state, which may or may not be due to medication side effects. To what extent does this behavior measure up to the usual standards of ethical medical care? Not in the least. Are we then willing to condemn the physician's actions as unethical? Perhaps not quite yet. Indeed, we might conclude that the physician is acting ethically after all.

For in our example, the physician is caring for the patient as part of a research protocol. The procedure involves comparing the efficacy of two medications, assigned at random, and administered on a double-blind basis. Dosages are determined in advance and standardized, to permit clearer estimation of the comparative efficacy and side effects of the medications. Although the research physician has turned aside from medicine's usual dedication to patients' interests (we might more accurately refer to patients here as "research subjects"), he or she would not be condemned for this behavior. Rather, it would be generally acknowledged that

trists who conduct evaluations for legal purposes do not enter into a physician-patient relationship, and therefore the ethical principles that apply in the latter situation are different from those in the former. As numerous commentators have recognized, were forensic psychiatrists to be charged with pursuing subjects' best interests and avoiding harm—as are their clinical colleagues—their evaluations would be worthless to the courts.[4, 22] They would be no more than advocates: junior lawyers doing their best to win a case for their clients. Inherent in the value of the forensic evaluation for the courts is the idea that information adverse to the subject's interests might well be derived from the evaluation and that the forensic expert will truthfully present such data when they are relevant to the legal issue at hand.

Forensic psychiatrists, therefore, like all other physicians whose roles may sometimes depart from the paradigm of the treatment setting, require a distinct set of ethical principles to guide their work. There is no shame in this reality, just as clinical researchers ought to feel no compunctions about observing a code of ethics distinct to their role. Indeed, Stone recognized the inevitability of this conclusion in his chastisement of forensic psychiatry for lacking ethical bearings.[1] His error came in suggesting that it is not possible to identify an alternative set of principles to take the place of those that function in the clinical realm. It is to that task that I now turn.

Principles of Ethics for Forensic Psychiatry

Recalling that the underlying premise for all professional ethics is that society has an interest in advancing certain important moral values, we must begin by asking which values forensic psychiatry is intended to promote. It seems clear that society prizes psychiatric testimony in court because of its potential to advance the interests of justice: the fair adjudication of disputes and the determination of innocence or guilt. Psychiatrists provide information that helps the courts to determine who ought not to be tried at a given point in time, because they are incapable of assisting in their defense; who should not be punished for the acts they have committed, because they lack moral responsibility; who have been subject to psychological injury as the result of others' negligence; and who are so impaired as to be reasonably unable to work. Testimony on these and other subjects is sought from forensic experts because jurists believe that when they are in possession of that testimony they are better able to reach accurate judgments on these very difficult issues.

If justice is the value to be advanced by forensic psychiatrists, what does that imply about the ethical principles that should guide their work? Two primary ethical principles can be derived from this functional analysis. A strong hint with regard to the first principle comes from the oath to which witnesses swear as they prepare to testify: ". . . to tell the truth, the

ethical contours may differ somewhat from the ethical parameters associated with the role of expert witness.[21] Although a more detailed consideration of this function is warranted, that is not the focus here.

nating evidence became available. Under the American constitutional system, none of this is permitted. Rather, we temper our justice system's pursuit of truth with the recognition that sometimes other values must take precedence. Although one might conceptualize the values underlying the exclusion of probative evidence in a variety of ways, I think it is fair to construe them as representing society's commitment to a respect for persons, even when those persons are suspected of having committed crimes.

The implications of the moral rule of respect for persons differ for the various actors in the criminal justice system, because their roles place them at risk for violating this principle in different ways. For the police, their entitlement to use physical force to protect social order creates the risk that unnecessary force may be used.[26] For prosecutors, the discretion afforded in deciding what charges to file or whether to seek the death penalty creates the potential for the intrusion of illegitimate factors such as the defendant's race or sexual orientation into their decisions.[27] In the case of forensic psychiatrists, the major risk is that subjects of forensic evaluations will assume that an evaluating psychiatrist is playing a therapeutic role and, therefore, that the usual ethics of the clinical setting apply. "This person is a physician," they may reason. "Surely she is here to help me, and at least will do me no harm. I am safe in speaking freely about whatever I choose."

Respecting persons means acting to negate the risks associated with one's role. Thus, the police must avoid use of unnecessary force, and prosecutors must strive to exclude racial and other personal characteristics of defendants from influencing their decisions. Forensic psychiatrists, in turn, must undercut subjects' beliefs that they, acting in the usual way that physicians act, are placing subjects' interests above all other considerations. Although allowing subjects to hold such beliefs might be an effective means of gathering information, it is inherently deceptive and exploitive, and fails to respect subjects as persons.

Forensic psychiatrists, to avoid violating the rule of respect for persons, must make clear to the subjects of their evaluations who they are, what role they are playing in the case (including which side they are working for), the limits on confidentiality, and—of particular importance—that they are not serving a treatment function.[28] Just as in the research setting, where the fidelity of a physician to the interests of the research subject is similarly altered, care must be taken to insure that the subject is aware of the different parameters of this situation.[§]

This dimension of the obligation to respect persons sometimes goes by the rubric of "informed consent." Insofar as use of that phrase implies an identity with informed consent in clinical contexts, I think the term is misleading. Subjects often submit to forensic examinations under coercion and, in some settings, forensic

[§] A variety of suggestions have been made as to how to respond if it appears that the subject has not grasped the difference between a forensic and a clinical evaluation, or loses an appreciation of the differences during the course of the evaluation. These suggestions range from reinforming the subject, to stopping the evaluation, to consulting with the subject's attorney or the judge, to excluding any testimony derived from the evaluation.[7, 28, 29]

cept the pursuit of justice as a basis for forensic ethics is not to say that forensic psychiatrists thereby surrender the right to determine with what actions it is appropriate to become involved, or that they avoid the opprobrium associated with participating in morally reprehensible acts.

In a similar vein, with regard to the moral ideal or aspiration of acting beneficently toward persons, such actions by forensic psychiatrists may be praiseworthy, even though they cannot be said to be part of their professional role. Conversely, although forensic psychiatrists may win acclaim for performing beneficent acts (e.g., diagnosing a melanoma in a subject they are interviewing), they should not be subject to professional sanction for failing to do so.

An Alternative Approach

What other ways might there be to think about ethics in forensic psychiatry, and how do they compare with the theory presented here? The leading alternative, embraced by several authors, although never fully elaborated or justified at the theoretical level, might be called a theory of mixed duties. According to this framework, forensic psychiatrists retain some (usually unspecified) measure of obligation to the principles of beneficence and nonmaleficence that underlie clinical ethics, in addition to whatever duties may be specific to the forensic arena.

Various commentators differ on the degree of priority these clinical principles demand. Some argue that they obligate psychiatrists only to the extent that psychiatrists can fulfill the duties of beneficence and nonmaleficence without interfering with their forensic functions.[28] Others, however, hold open the possibility that clinical duties may take center stage, maintaining that "[t]raditional medical values should be one factor in the balancing process" used by forensic psychiatrists to resolve ethical dilemmas, "given varying weight by individual practitioners in different circumstances."[30] Perhaps the most radical view is offered by a philosopher, who claims, "In spite of the other things that they are called on to do [referring specifically to forensic evaluations], psychiatrists and other doctors must surely be seen *primarily* as healers, with *primum non nocere* as their guiding light."[31]

The problems with this model of mixed duties are evident at the levels of both theory and practice. On the theoretical plane, as should be clear from the discussion above, the justification for professional ethics lies in its capacity to promote a distinct set of values that are embedded in the functions of the professionals in question. Ethical principles relevant to the forensic role, therefore, cannot legitimately be drawn from the clinical realm, because the values that underlie each function are so different: clinicians seek to promote health, while forensic evaluators seek to advance the interests of justice. As the medical philosopher Edmund Pellegrino has noted, "[t]he subject-physician relationship [i.e., in the forensic evaluation context] does not carry the implication or promise of primacy for the patient's welfare that [is] intrinsic to a true medical relationship."[18] Principles based on the pursuit of health,

forensic psychiatrists support the blurring of the boundaries between clinical and forensic ethics.

When we turn from the theoretical to the practical level, an additional good reason appears to shun the model of mixed duties. Many writers have worried about the "double agent problem" in forensic work. Stone, for one, has come to see "the intermingling of the roles of expert and therapist" as one of the major issues in forensic ethics.[7] He is concerned that the forensic psychiatrist might take advantage of the subject's tendency to view the evaluator as a treater (i.e., to develop a therapeutic transference), in order to extract information that will later be revealed in court to the subject's detriment. His proposal is that "forensic psychiatrists should as a first principle eschew any overlap between their clinical and evaluative functions." Indeed, if the evaluation begins to take on therapeutic overtones, Stone would demand that the forensic psychiatrist withdraw from testifying on the basis of the information obtained.#

The extent of the double agent problem, that is, the frequency with which subjects in forensic evaluations develop therapeutic transferences, is an open empirical question. Nonetheless, as I noted above, I consider failure to address this issue as constituting a deception of the subject, which violates the principle of respect for persons. Stone's key insight, I think, is that double agency is a matter of countertransference as well as transference. That is, when the forensic psychiatrist approaches the subject as a treater would, the subject responds accordingly. The first task in combatting the problem is to persuade both parties that the situation in which they find themselves bears no relationship to the therapeutic setting. The psychiatrist is not present to help the subject; his or her job is to ascertain the truth relevant to the legal issue at hand.

The most deleterious effect of the insistence on holding on to therapeutic principles of ethics in forensic work, therefore, may be its consequences for psychiatrists' and subjects' perceptions of the evaluators' role. If forensic psychiatrists persuade themselves that they maintain a residual duty—of a professional nature—to benefit and not to harm evaluees, they are likely to communicate that to their subjects.** The psychiatrist, for example, who believes he has a duty to evaluate the efficacy of a subject's current treatment, when that is irrelevant to the legal issue in dispute, will ask the kind of questions that treating psychiatrists ask, and should not be surprised to receive the same kind of answers. Both

Unfortunately, Stone never specifies how one might determine when an evaluation "has turned into a therapeutic encounter," clearly the key question on which the implementation of his proposal depends.

** A similar phenomenon, which I have called the "therapeutic misconception," occurs for much the same reason between clinical researchers and their subjects. Potential research subjects enter discussions over participating in research with the expectation that physician-investigators will manifest that same loyalty to their personal care that they have experienced in ordinary clinical settings. Researchers, often uncomfortable with the different ethical framework under which they are operating, may encourage these beliefs through the words they use and the attitudes they convey. When subjects and family members, however, discover that subjects' interests have not been given primacy by the researchers, they feel angry and betrayed.[32] Clarifying prospectively the actual scope of researchers' ethical duties is the only way to prevent this unfortunate outcome.

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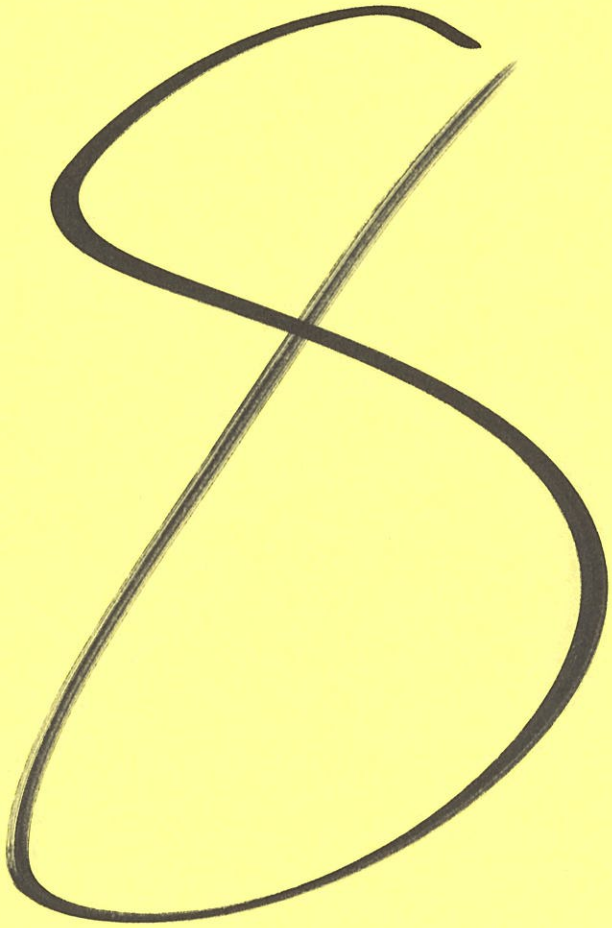


Doctor's Orders -- Spill Your Guts; [HOME EDITION]

M. Gregg Bloche and Jonathan H. Marks. **Los Angeles Times**. Los Angeles, Calif.: Jan 9, 2005. pg. M.1

Full Text (1515 words)

Credit the folks who ran Abu Ghraib for their wit. "The database is lonely," says a smiley face in a slide show for new interrogators prepared a year ago. "You can help! Visit the database every time you spend time with any of our esteemed guests. Tell the database about what fun conversation you and your guests had." The last slide is a cartoon of an interrogation session. "I realize it sounds rather cliche, but we have ways of making you talk," its caption reads.

At Abu Ghraib, Guantanamo Bay, Cuba, and "undisclosed locations," some U.S. military interrogators used troubling methods to try to get their captives to talk. Many of their efforts have been widely reported; some may have risen to the level of torture under international law. What is less known -- but equally disturbing -- is that military doctors become arbiters, even planners, of aggressive interrogation practice, including prolonged isolation, sleep deprivation and exposure to temperature extremes.

An August 2002 Justice Department memo, sought by White House Counsel Alberto R. Gonzales to protect interrogators against prosecution for employing such methods as sleep deprivation, defined torture in medical terms. Coercive measures, the memo stated, don't constitute torture unless they bring about "death, organ failure ... serious impairment of bodily functions" or prolonged and severe mental illness. Use of mind-altering drugs is OK, so long as it doesn't "disrupt profoundly the senses or the personality." Even when these lines are crossed, the memo held, interrogators aren't torturers if they act "in good faith" by "surveying professional literature" or "consulting with experts."

The International Committee of the Red Cross, which monitors wartime detention practices, alleges that medical personnel at Guantanamo shared clinical information with interrogators, in "flagrant violation of medical ethics," to extract more information from detainees. The Pentagon says the charge is false. But our inquiry into the role that health professionals played in military intelligence-gathering in Iraq and Guantanamo has found a pattern of reliance on medical input. Not only did caregivers pass clinical data to interrogators, physicians and other health professionals helped craft and carry out coercive interrogation plans.

Such conduct violated U.S. obligations under the Geneva Convention, which bar threatening, insulting and other abusive treatment of prisoners. There is also probable cause to suspect that some physicians were complicit in the use of interrogation methods that constitute torture under international law.

Piercing the veil of silence surrounding Abu Ghraib and Guantanamo poses unusual difficulties. Military personnel knowledgeable about interrogation practices or medical care at these sites were reluctant to speak with us. Some cited orders not to discuss their service; others pointed to a general understanding, not expressed as an order, that public discussion of their experiences was ill advised. One, Maj. David Auch, commander of the clinical unit that staffed Abu Ghraib

threat to the life of others (for example, a prisoner who tells his doctor about an impending terror attack), breach of doctor-patient confidentiality to save life is appropriate. But revealing health information to interrogators undermines detainees' trust in their doctors, a prerequisite for adequate care.

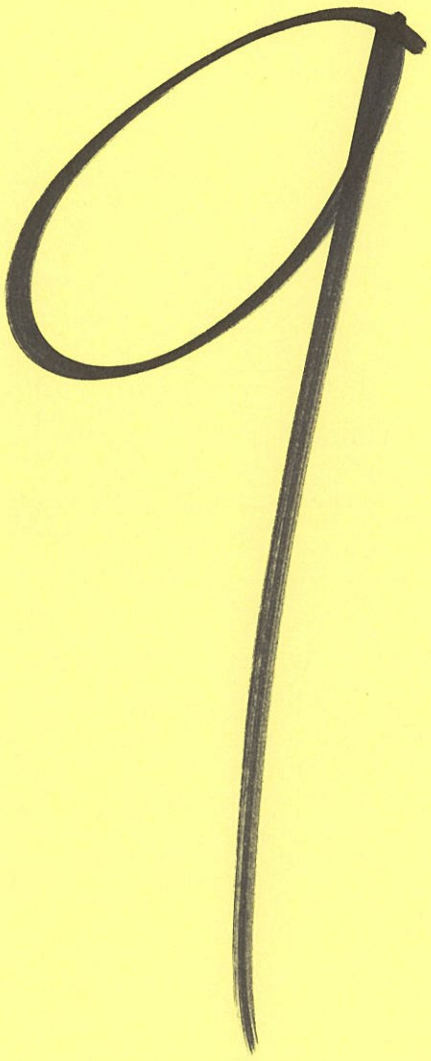
How did military physicians who advised or served with Biscuits justify this role to themselves? Some may have conflated Geneva protections with the ban on torture. So long as interrogation strategies didn't rise to the level of torture, they could see their conduct as lawful. Other physicians feared prosecution for disobeying orders more than they worried about the consequences of following illegal orders.

Some military doctors advanced another rationalization: Whatever their obligations under the international human rights law and the laws of war, medical ethics do not apply when they devote their skills to intelligence-gathering and other war-fighting functions. In such cases, these physicians say, they are combatants, not physicians, because they apply their knowledge to achieve military ends. A medical degree, Tornberg told us, isn't a "sacramental vow." When a doctor participates in interrogation, "he's not functioning as a physician," and the Hippocratic ideal of fidelity to patients is beside the point.

The Hippocratic ideal does fail to capture the breadth of the profession's social role. Doctors routinely serve criminal justice, public health and other social purposes, sometimes at the expense of individuals' well-being. But the proposition that, in so doing, they don't act as physicians is self-contradictory. It is their mix of technical skill, caring ethos and moral authority that qualifies them to assume these roles. It is why the architects of the United States' post-9/11 detainee counter-resistance policy looked to medicine.

To their credit, some military physicians in leadership roles seek a larger public discussion of their profession's moral dilemmas in the war on terrorism. So far, the Pentagon's civilian leadership has stymied these efforts by telling doctors not to go public with their ethics concerns. This has left them isolated from their civilian peers.

The therapeutic mission is medicine's primary role, whether or not doctors wear their country's uniform. But military physicians make a national service commitment that is sometimes at odds with Hippocratic ideals. We owe them gratitude for making this commitment -- and for their courage and sacrifice in Iraq and other post-9/11 theaters of war. But Abu Ghraib and Guantanamo should remind us that there are some things doctors must not do.



EDITORIAL DESK

Triage At Abu Ghraib
By M. GREGG BLOCHE AND JONATHAN H. MARKS (NYT) 820 words
Published: February 4, 2005

YOU probably remember the photograph. A tiny female M.P. in baggy fatigues stands over a nude Iraqi man, holding him on a leash. He lies limp, on his side, utterly humiliated, an icon of wartime excess.
The conduct depicted in that photo is difficult to justify under any circumstances. But as it turns out, a few weeks before the photo was taken, use of a leash was approved on medical grounds, according to the Army doctor who commanded the medical unit that cared for Abu Ghraib's prisoners and the American soldiers who guarded them.

During an inquiry we conducted for The New England Journal of Medicine, the doctor, Maj. David Auch, told us that some of the prisoners at Abu Ghraib were psychotic and out of control. One, he said, would repeatedly strip off his clothes and smash his head against the wall. After handcuffs and a helmet failed to stop him and with straitjackets unavailable, some soldiers suggested the leash. Major Auch granted their request. "My concern was whatever it took to keep him from getting hurt," he said.

It is easy to criticize Major Auch for allowing M.P.'s to use a leash, but it is difficult to say what he should have done instead. He had antipsychotic drugs on hand but no psychiatrists to prescribe them, and he lacked the experience to give these powerful drugs himself.

So the leashed detainee went untreated, as did hundreds of others with mental disorders. The lone psychologist who accompanied Major Auch, First Lt. Joseph Wehrman, was troubled by what he found on their weekly visits. Up to 5 percent of the detainee population (which averaged 2,000 in late 2003 and early 2004) was mentally ill, Lieutenant Wehrman told us, but to his knowledge, none of the prisoners received medication.

The atmosphere at Abu Ghraib hardly promoted sanity. Mortar shells landed almost daily, according to military personnel we interviewed, and prisoners often rioted, sometimes using smuggled weapons, with deadly effect. In late 2003, Major Auch's unit set up a field hospital, bringing a full-time medical presence to the prison for the first time. For the dozen or so clinicians assigned to the hospital, the daily routine was surreal.

At times the hospital lacked basic supplies, according to members of the clinical staff, and at times it maintained a surgical service without surgeons. Sometimes the hospital ran out of chest tubes, intravenous fluids or medicines. Medical staff members improvised, taking tubes from patients when they died and reusing them, without sterilization.

PERSPECTIVE

When Doctors Go to War

M. Gregg Bloche, M.D., J.D., and Jonathan H. Marks, M.A., B.C.L.

When military forces go into combat, they are typically accompanied by medical personnel (physicians, physician assistants, nurses, and medics) who serve in noncombat roles. These professionals are bound by international law to treat wounded combatants from all sides and to care for injured civilians. They are also required to care for enemy prisoners and to report any evidence of abuse of detainees. In exchange, the Geneva Conventions protect them from direct attack, so long as they themselves do not become combatants.

Recently, there have been accounts of failure by U.S. medical personnel to report evidence of detainee abuse, even murder, in Iraq and Afghanistan.[1] There have also been claims, less well supported, that medics and others neglected the clinical needs of some detainees. The Department of Defense says it is investigating these allegations, though no charges have been brought against caregivers.

But Pentagon officials deny another set of allegations: that physicians and other medical professionals breached their professional ethics and the laws of war by participating in abusive interrogation practices. The International Committee of the Red Cross (ICRC) has concluded that medical personnel at Guantanamo Bay shared health information, including patient records, with army units that planned interrogations.[2] The ICRC called this "a flagrant violation of medical ethics" and said some of the interrogation methods used were "tantamount to torture."[2] The Pentagon answered that its detention operations are "safe, humane, and professional" and that "the allegation that detainee medical files were used to harm detainees is false."[2]

Our own inquiry into medical involvement in military intelligence gathering in Iraq and Guantanamo Bay has revealed a more troublesome picture. Recently released documents and interviews with military sources point to a pattern of such involvement, including participation in interrogation procedures that violate the laws of war. Not only did caregivers pass health information to military intelligence personnel; physicians assisted in the design of interrogation strategies, including sleep deprivation and other coercive methods tailored to detainees' medical conditions. Medical personnel also coached interrogators on questioning technique.

Physicians who did such work tend not to see these practices as unethical. On the contrary, a common understanding among those who helped to plan interrogations is that physicians serving in these roles do not act as physicians and are therefore not bound by patient-oriented ethics. In an interview, Dr. David Tornberg, Deputy Assistant Secretary of Defense for Health Affairs, endorsed this view. Physicians assigned to military intelligence, he contended, have no doctor–patient relationship with detainees and, in the absence of life-threatening emergency, have no obligation to offer medical aid.

Most people we interviewed who had served or spent time in detention facilities in Iraq or Guantanamo Bay reported being told not to talk about their experiences and impressions. Dr. David Auch, commander of the medical unit that staffed Abu Ghraib during the time of the abuses made notorious by soldiers' photographs, said military intelligence personnel told his medics and physician assistants not to discuss deaths that occurred in detention. Physicians who cared for so-called high-value detainees were especially hesitant to share their observations.

Yet available documents, the consistency of multiple confidential accounts, and confirmation of key facts by persons who spoke on the record make possible an understanding of the medical role in military intelligence in Iraq and Guantanamo. They also shed light on how those involved tried to justify this role in ethical terms.

In testimony taken in February 2004, as part of an inquiry into abuses at Abu Ghraib (and recently made public under the Freedom of Information Act

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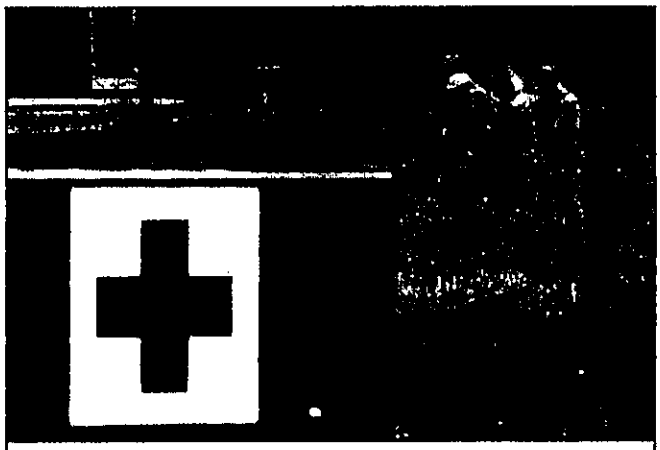

Chris Hondros, Getty Images.

Guantanamo Bay, Cuba.

the breadth of the profession's social role. This role encompasses the legitimate needs of the criminal and civil justice systems, employers' concerns about workers' fitness for duty, allocation of limited medical resources, and protection of the public's health.

But the proposition that doctors who serve these social purposes don't act as physicians is self-contradictory. Their "physicianhood" — encompassing technical skill, scientific understanding, a caring ethos, and cultural authority — is the reason they are called on to assume these roles. The forensic psychiatrist's judgments about personal responsibility and competence rest on his or her moral sensibility and grasp of mental illness. And the military physician's contributions to interrogation — to its effectiveness, lawfulness, and social acceptance in a rights-respecting society — arise from his or her psychological insight, clinical knowledge, and perceived humanistic commitment.

In denying their status as physicians, military doctors divert attention from an urgent moral challenge — the need to manage conflict between the medical profession's therapeutic and social purposes. The Hippocratic ethical tradition offers no road map for resolving this conflict, but it provides a starting point. The therapeutic mission is the profession's primary role and the core of physicians' professional identity. If this mission and identity are to be preserved, there are some things doctors must not do. Consensus holds, for example, that physicians should not administer the death penalty, even in countries where capital punishment is lawful. Similarly, when physicians are involved in war, some simple rules should apply.

Physicians should not use drugs or other biologic means to subdue enemy combatants or extract information from detainees, nor should they aid others in doing so. They should not be party to interrogation practices contrary to human rights law or the laws of war, and their role in legitimate interrogation should not extend beyond limit setting, as guardians of detainees' health.[5] This role does not carry patient care responsibilities, but it requires physicians to tell detainees about health problems they find and to make treatment available. It also demands that physicians document abuses and report them to chains of command. By these standards, military medicine has fallen short.

The conclusion that doctors participated in torture is premature, but there is probable cause for suspecting it. Follow-up investigation is essential to determine whether they helped to craft and carry out the counter-resistance strategies — e.g., prolonged isolation and exposure to temperature extremes — that rise to the level of torture.

But, clearly, the medical personnel who helped to develop and execute aggressive counter-resistance plans thereby breached the laws of war. The Third Geneva Convention states that "[n]o physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever." It adds that "prisoners of war who refuse to answer [questions] may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind." The tactics used at Abu Ghraib and Guantanamo were transparently coercive, threatening, unpleasant, and disadvantageous. Although the Bush administration took the position (rejected by the ICRC) that none of the Guantanamo detainees were "prisoners of war," entitled to the full protections of the Third Geneva Convention, it has acknowledged that combatants detained in Iraq are indeed prisoners of war, fully protected under this Convention.

The Surgeon General of the U.S. Army has begun a confidential effort to develop rules for health care professionals who work with detainees. Such an initiative is much needed, but it ought not to happen behind a veil of secrecy. Ethicists, legal scholars, and civilian professional leaders should participate, and the process should address role conflict in medicine more generally. An Institute of Medicine study committee, broadly representative of competing concerns (including the military's),

Ethical Concerns in Forensic Consultation Regarding National Safety and Security

Charles Patrick Ewing
Michael G. Gelles

SUMMARY. Psychologists and psychiatrists are frequently called upon to provide consultation in terrorism, espionage and/or intelligence cases involving the vital interests of the United States. Often these are cases in which the client is not the individual about whom advice is being sought but rather the military, a government intelligence agency, or law enforcement, and the consultant must act within parameters set by law and/or dictated by concerns for public safety or national security. In some of these cases, psychological and psychiatric consultants are asked to function in non-traditional roles that may conflict with the currently accepted ethical principles of their professions. This article explores some of the ethical dilemmas peculiar to consultations in this increasingly important context.

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with military, intelligence, and law enforcement agencies now find themselves in uncharted ethical waters. As a further result, some of these professionals may steer clear of such vital work for fear of stepping on an ethical land-mine and jeopardizing their professional standing, licenses, and livelihoods.

This article briefly explores some of the ethical concerns peculiar to psychological and psychiatric consultation where the client is not the individual about whom advice is being sought but rather the military, government intelligence, or law enforcement, and the consultant must act within parameters set by law and/or dictated by concerns for public safety or national security.

Among the issues to be considered are ethical concerns that arise in the following contexts:

1. The consultant's input may have serious consequences for the individual in question but, for legal and/or public safety/national security reasons, the consultant has no direct access to the individual.
2. The consultant has professional contact with the individual in question but law, national security and/or public safety concerns dictate that the true purpose of the contact be withheld from the subject of the investigation.
3. Certain aspects of the consultant's role are dictated in part by legal parameters outside the consultant's control.

PERTINENT STATEMENTS OF ETHICAL PRINCIPLES

The professional practices of psychologists and psychiatrists are directed not only by individual conscience but also by written guidelines. For psychologists, these guidelines take the form of the American Psychological Association's "Ethical Principles of Psychologists" (American Psychological Association, 1992; hereinafter "APA Ethical Principles") and the "Specialty Guidelines for Forensic Psychologists" jointly promulgated by the American Psychology-Law Society and the American Academy of Forensic Psychology (Committee on Ethical Guidelines for Forensic Psychologists, 1991; hereinafter "APLS-AAFP Specialty Guidelines"). For psychiatrists, such guidelines are spelled out in the American Psychiatric Association's "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" (American Psychiatric Association, 1998; hereinafter "Principles of Medical Ethics") and the "Ethical Guidelines for the Practice of Forensic Psy-

Analysis Program (BAP), which included a psychologist, was designed "to examine [Squillacote's] personality . . . and based on this examination, to provide suggestions . . . that could be used in furthering the objective of this investigation to obtain evidence regarding the subject's espionage activity" (*United States v. Squillacote*, 2001, p. 550).

The BAP profile concluded that Squillacote suffered from depression, was taking anti-depressant medications, had a "narcissistic" and "histrionic" personality, and demonstrated "poor impulse control," "excessively emotional behavior," and an excessive need for "reassurance, approval, and praise" (Petition for a Writ of Certiorari, *United States v. Squillacote*, 2000).

The profilers offered specific recommendations on how to exploit Squillacote's "emotional vulnerability" (*United States v. Squillacote*, p. 550). The BAP report suggested using a sting operation conducted by a mature male undercover agent, who should "capitalize on [Squillacote's] fantasies and intrigue" by making a "friendly overture," and "acting professional and somewhat aloof yet responsive to her moods" (*Squillacote*, p. 551). According to the recommendation, "The initial meeting should be brief and leave Squillacote beguiled and craving more attention" (*Squillacote*, p. 551).

The recommended operation was implemented and was effective. Squillacote met four times with an undercover FBI agent posing as a South African intelligence official, and provided him with classified documents she obtained from the Department of Defense. After several months of contacts with the agent, Squillacote was arrested and convicted of conspiracy to transmit information relating to the national defense, attempted transmission of national defense information, obtaining national defense information, and making false statements.

Some commentators found the work of the FBI psychologist in the Squillacote case to be unethical. For example, a forensic psychiatrist, Janofsky (2001), argued that for a psychiatrist to have engaged in such professional conduct would have constituted "a gross violation of professional ethics, because the overt intent of the BAP was to deceive deliberately and exploit the defendant in ways directly related to her unique psychological vulnerabilities" (p. 450).

Another psychiatrist, Candilis (2001), concluded that "Professional ethics, the social contract, and the common balance between individual and state's rights begin to militate against the kind of analysis conducted by the FBI's psychologist" (pp. 454-455). Candalis also urged that such conduct gave the appearance of wrongdoing and that creating such appearance is unethical because it damages trust in the profes-

The "APA Ethical Principles" state that "Psychologists seek to contribute to the welfare of those with whom they interact professionally. In their professional actions, psychologists weigh the welfare and rights of their patients or clients, students, supervisees, human research participants, and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts and to perform their roles in a responsible fashion that avoids or minimizes harm" (Principle E).

The APA Ethical Principles also indicate that "Psychologists are aware of their professional and scientific responsibilities to the community and the society in which they work and live. They apply and make public their knowledge of psychology in order to contribute to human welfare. Psychologists are concerned about and work to mitigate the causes of human suffering" (Principle F).

These global statements of ethical principles support the notion advanced by Grisso that the consequences of doing harm to an individual, as in the Squillacote matter, must be balanced against the consequences of not doing such harm. While one can only speculate what the harm to the United States and its citizens might have been had Squillacote not been apprehended, it is not unreasonable to suggest that such harm might have been substantial. Many instances of espionage have not only undermined national safety and security but have resulted in many deaths. The FBI psychologist did not violate the ethical principles of his profession but rather upheld those principles by risking harm to one individual in order to avert a potentially much greater harm to a multitude of individuals.

CONSULTANT HAS CONTACT WITH THE SUBJECT BUT THE SUBJECT IS NOT AWARE OF THE CONSULTANT'S FUNCTION

In some instances, unlike the Squillacote investigation, mental health consultants to military, national security, and law enforcement operations have direct access to subjects they are asked to evaluate. If the subject of the evaluation is fully informed of the identity and profession of the evaluator and the nature and potential consequences of the evaluation, and gives informed consent to the evaluation, there will usually be no ethical concern. However, in many cases, for strategic reasons, authorities may wish to have a subject covertly evaluated by a mental health professional or overtly evaluated but without revealing the true

In some of these investigations, the psychologist consultant either participates in or observes the interview but the detainee is not informed of the professional identity of the psychologist. In any event, the psychologist utilizes his or her psychological training and experience to assist the government in gaining the detainee's cooperation and/or obtaining behavioral data that will otherwise materially assist the interrogators.

In all of the above situations, the balancing test discussed earlier would appear to ethically justify the conduct of the mental health professional. Clearly in each of these cases, the harm imposed (active or passive deception by the professional leading to potentially adverse consequences for the subject) is arguably much less than the harm likely to be avoided (continued espionage and/or terrorism that could cost many lives and seriously undermine national security). However, the mental health professional's conduct in each of these cases just as clearly violates specific aspects of the pertinent statements of ethical principles.

The "Principles of Medical Ethics" indicate that "Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination" (Section 4.6). This basic restatement of the fundamental requirement of informed consent is echoed in the "APA Ethical Principles" which state that: "When a psychologist agrees to provide services to a person or entity at the request of a third party, the psychologist clarifies to the extent feasible, at the outset of the service, the nature of the relationship with each party. This clarification includes the role of the psychologist (such as therapist, organizational consultant, diagnostician, or expert witness), the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality . . . If there is a foreseeable risk of the psychologist's being called upon to perform conflicting roles because of the involvement of a third party, the psychologist clarifies the nature and direction of his or her responsibilities, keeps all parties appropriately informed as matters develop . . . " (Section 1.21(a)).

Similarly, the "AAPL Ethical Guidelines" state that "The informed consent of the subject of a forensic evaluation is obtained when possible. Where consent is not required, notice is given to the evaluee of the nature of the evaluation. If the evaluee is not competent to give consent, substituted consent is obtained in hereinafter accordance with the laws of the jurisdiction" (Section III).

fessions, the psychologist's conduct might well be judged a violation of the informed consent doctrine spelled out in the "Principles of Medical Ethics," the "APA Ethical Principles," the "AAPL Ethical Guidelines" and the "APLS-AAFP Specialty Guidelines" described in the preceding section of this article. Moreover, even though videotaping the interview without the subject's knowledge was done pursuant to legal requirements, the psychologist might still be regarded as violating ethical standards. For example, the APA Ethical Principles state that: "In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code, in addition to applicable laws and psychology board regulations. If the Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard" (Introduction).

SUMMARY AND A CALL TO ACTION

As the above examples illustrate, strict application of the prevailing ethical standards in psychology and psychiatry would effectively preclude psychologists and psychiatrists from engaging in most of the kinds of professional conduct described in this article. Indeed, in the eyes of some, psychologists and psychiatrists should be ethically precluded from engaging in any of the conduct described.

Such judgments, if taken seriously, put many government psychologists and psychiatrists between the proverbial rock and hard place. Their employment duties, allegiance to their nation, respect for human life and common sense all militate in favor of the kind of professional conduct described in this article–i.e., professional practice utilizing psychological and psychiatric expertise to reduce threats to our national safety and security. But as things stand now, by engaging in such conduct, they risk disrespecting the ethical principles of their professions, censure by or expulsion from their professional organizations, and possible suspension or loss of their professional licenses to practice.

Imposing the sort of balancing test discussed earlier would, in our view, render the professional conduct described in this article ethical. At the same time, however, such a standard might also place the stamp of professional ethical approval on conduct that we and others would regard as clearly unethical–e.g., consultation regarding the use of psychological torture of a terrorist suspect in order to obtain information that would save the lives of thousands of potential victims. Moreover, we acknowledge that not all psychologists and psychiatrists would agree

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POLICY FORUM

SOCIAL PSYCHOLOGY

Why Ordinary People Torture Enemy Prisoners

Susan T. Fiske, Lasana T. Harris, Amy J. C. Cuddy

As official investigations and courts-martial continue, we are all taking stock of the events at Abu Ghraib last year. Initial reactions were shock and disgust. How could Americans be doing this to anyone, even Iraqi prisoners of war? Some observers immediately blamed "the few bad apples" presumably responsible for the abuse. However, many social psychologists knew that it was not that simple. Society holds individuals responsible for their actions, as the military court-martial recognizes, but social psychology suggests we should also hold responsible peers and superiors who control the social context.

Social psychological evidence emphasizes the power of social context; in other words, the power of the interpersonal situation. Social psychology has accumulated a century of knowledge about how people influence each other for good or ill (*1*). Meta-analysis, the quantitative summary of findings across a variety of studies, reveals the size and consistency of such empirical results. Recent meta-analyses document reliable experimental evidence of social context effects across 25,000 studies of 8 million participants (*2*). Abu Ghraib resulted in part from ordinary social processes, not just extraordinary individual evil. This Policy Forum cites meta-analyses to describe how the right (or wrong) social context can make almost anyone aggress, oppress, conform, and obey.

Virtually anyone can be aggressive if sufficiently provoked, stressed, disgruntled, or hot (*3–6*). The situation of the 800th Military Police Brigade guarding Abu Ghraib prisoners fit all the social conditions known to cause aggression. The soldiers were certainly provoked and stressed: at war, in constant danger, taunted and harassed by some of the very citizens they were sent to save, and their comrades were dying daily and unpredictably. Their morale suffered, they were untrained for the job, their command climate was lax, their return home was a year overdue, their identity as disciplined soldiers was gone, and their own amenities were scant (*7*). Heat and discomfort also doubtless contributed.

The fact that the prisoners were part of a group encountered as enemies would only exaggerate the tendency to feel spontaneous prejudice against outgroups. In this context, oppression and discrimination are synonymous. One of the most basic principles of social psychology is that people prefer their own group (*8*) and attribute bad behavior to outgroups (*9*). Prejudice especially festers if people see the outgroup as threatening cherished values (*10–12*). This would have certainly applied to the guards viewing their prisoners at Abu Ghraib, but it also applies in more "normal" situations. A recent sample of U.S. citizens on average viewed Muslims and Arabs as not sharing their interests and stereotyped them as not especially sincere, honest, friendly, or warm (*13–15*).

Even more potent predictors of discrimination are the emotional prejudices ("hot" affective feelings such as disgust or contempt) that operate in parallel with cognitive processes (*16–18*). Such emotional reactions appear rapidly, even in neuroimaging of brain activations to outgroups (*19, 20*). But even they can be affected by social context. Categorization of people as interchangeable members of an outgroup promotes an amygdala response characteristic of vigilance and alarm and an insula response characteristic of disgust or arousal, depending on social context; these effects dissipate when the same people are encountered as unique individuals (*21, 22*).

According to our survey data (*13, 14*), the contemptible, disgusting kind of outgroup—low-status opponents—elicits a mix of active and passive harm: attacking and fighting, as well as excluding and demeaning. This certainly describes the Abu Ghraib abuse of captured enemies. It also fits our national sample of Americans (*14*) who reported that allegedly contemptible outgroups such as homeless people, welfare recipients, Turks, and Arabs often are attacked or excluded (*14*).

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Given an environment conducive to aggression and prisoners deemed disgusting and subhuman (*23*), well-established principles of conformity to peers (*24, 25*) and obedience to authority (*26*) may account for the widespread nature of the abuse. In combat, conformity to one's unit means survival, and ostracism is death. The social context apparently reflected the phenomenon of people trying to make sense of a complex, confusing, ambiguous situation by relying on their immediate social group (*27*). People rioted at St. Paul's Church, Bristol UK, in 1980, for example, in conformity to events they saw occurring in their immediate proximity (*28*). Guards abuse prisoners in conformity with what other guards do, in order to fulfill a potent role; this is illustrated by the Stanford

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Irreconcilable Conflict Between Therapeutic and Forensic Roles

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Despite being contrary to good patient care and existing clinical and forensic practice guidelines, some therapists nevertheless engage in dual clinical and forensic roles. Perhaps because an injured litigant seeking treatment is required to engage in 2 distinct roles (litigant and patient), care providers may be tempted to meet both sets of that person's needs. Through the presentation of 10 principles that underlie why combining these roles is conflicting and problematical, the authors stress the importance of avoiding such conflicts, avoiding the threat to the efficacy of therapy, avoiding the threat to the accuracy of judicial determinations, and avoiding deception when providing testimony.

With increasing frequency, psychologists, psychiatrists, and other mental health professionals are participating as forensic experts in litigation on behalf of their patients. Factors such as tightened insurance reimbursement rules, a growing market for forensic mental health professionals, and zealous patient advocacy by therapists have combined to induce many therapists, including those who once zealously avoided the judicial system, to appear, often willingly, as forensic expert witnesses on behalf of their patients. Although therapists' concerns for their patients and for their own employment is understandable, this practice constitutes engaging in dual-role relationships and often leads to bad results for patients, courts, and clinicians.

Although there are explicit ethical precepts about psychologists and psychiatrists engaging in these conflicting roles, they have not eliminated this conduct. One important factor contributing to this continued conduct is that psychologists and psychiatrists have not understood why these ethical precepts exist and how they affect the behavior of even the most competent therapists. When the reasons for the ethical precepts are understood, it is clear why no psychologist, psychiatrist, or other mental health professional is immune from the concerns that underlie them.

This article contrasts the role of therapeutic clinician as care provider and the role of forensic evaluator as expert to the court, acknowledges the temptation to engage in these two roles in the same matter, explains the inherent problems and argues strongly against doing so, and discusses the ethical precepts that discourage the undertaking of the dual roles, as well as the legal and professional responses to this dilemma. The specific problem addressed here is that of the psychologist or psychiatrist who provides clinical assessment or therapy to a patient–litigant and who concurrently or subsequently attempts to serve as a forensic expert for that patient in civil litigation.

Expert persons may testify as fact witnesses as well as either of two types of expert witnesses: treating experts and forensic experts. No special expertise beyond the ability to tell the court what is known from first-hand observation is required to be a fact witness. Being an expert person, however, does not preclude one from simply providing to the court first-hand observations in the role of a fact witness. What distinguishes expert witnesses from fact witnesses is that expert witness have relevant specialized knowledge beyond that of the average person that may qualify them to provide opinions, as well as facts, to aid the court in reaching a just conclusion. Psychologists and psychiatrists who provide patient care can usually qualify to testify as treating experts, in that they have the specialized knowledge, not possessed by most individuals, to offer a clinical diagnosis and prognosis. However, a role conflict arises when a treating therapist also attempts to testify as a forensic expert addressing the psycholegal issues in the case (e.g., testamentary capacity, proximate cause of injury, parental capacity).

Although in the preceding description the therapeutic relationship occurs first and the forensic role second, there are parallel concerns with the reverse sequence (i.e., the subsequent provision of therapy by a psychologist or psychiatrist who previously provided a forensic assessment of that litigant). There are also similar concerns about the treating therapist's role in criminal litigation. However, this article will only address civil litigation because the concerns and considerations arising in criminal litigation are somewhat different, such as therapy provided under court order and the provision of therapy and evaluation in forensic hospitals pending criminal responsibility or competency to stand trial determinations.

Role Conflict

In most jurisdictions, a properly qualified therapist testifies as a fact witness for some purposes, as he or she is expected to

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Table 1
Ten Differences Between Therapeutic and Forensic Relationships

		Care provision	Forensic evaluation
1.	Whose client is patient/litigant?	The mental health practitioner	The attorney
2.	The relational privilege that governs disclosure in each relationship	Therapist–patient privilege	Attorney-client and attorney work-product privilege
3.	The cognitive set and evaluative attitude of each expert	Supportive, accepting, empathic	Neutral, objective, detached
4.	The differing areas of competency of each expert	Therapy techniques for treatment of the impairment	Forensic evaluation techniques relevant to the legal claim
5.	The nature of the hypotheses tested by each expert	Diagnostic criteria for the purpose of therapy	Psycholegal criteria for purpose of legal adjudication
6.	The scrutiny applied to the information utilized in the process and the role of historical truth	Mostly based on information from the person being treated with little scrutiny of that information by the therapist	Litigant information supplemented with that of collateral sources and scrutinized by the evaluator and the court
7.	The amount and control of structure in each relationship	Patient structured and relatively less structured than forensic evaluation	Evaluator structured and relatively more structured than therapy
8.	The nature and degree of "adversarialness" in each relationship	A helping relationship; rarely adversarial	An evaluative relationship; frequently adversarial
9.	The goal of the professional in each relationship	Therapist attempts to benefit the patient by working within the therapeutic relationship	Evaluator advocates for the results and implications of the evaluation for the benefit of the court
10.	The impact on each relationship of critical judgment by the expert	The basis of the relationship is the therapeutic alliance and critical judgment is likely to impair that alliance	The basis of the relationship is evaluative and critical judgment is unlikely to cause serious emotional harm

roles is the identification of whose client the patient–litigant is. As implied by the name, the patient–litigant has two roles, one as therapy patient and another as plaintiff in the legal process. The patient–litigant is the client of the therapist for the purposes of treatment. The patient–litigant is as well the client of the attorney for guidance and representation through the legal system.

The nature of each relationship and the person who chooses to create it differs for therapy and forensic evaluation. The therapist is ultimately answerable to the client, who decides whether to use the services of a particular therapist; the forensic evaluator is ultimately answerable to the attorney, or the court in the case of a court-appointed expert, who decides whether to use the services of a particular forensic evaluator. The patient retains the therapist for treatment. The attorney (or the court) retains the forensic evaluator for litigation. This arrangement allows for the relationship that is most straightforward and free of conflict of interest. It best protects the parties' interests as well as the integrity of the therapist and the forensic evaluator.

Second, the legal protection against compelled disclosure of the contents of a therapist–patient relationship is governed by the therapist–patient privilege and can usually only be waived by the patient or by court order. Society seeks to further the goal of treatment through recognition of a privilege for confidential communications between a therapist and patient in most jurisdictions under a physician, psychiatrist, psychologist, or psychotherapist–patient privilege (Shuman & Weiner, 1987).

Legal protection against compelled disclosure of the contents of the forensic evaluator–litigant relationship is governed by the attorney–client and attorney–work-product privileges. Because the purpose of a forensic relationship is litigation, not treatment nor even diagnosis for the purpose of planning treatment, communications between a forensic examiner and a litigant are not protected under a physician–, psychiatrist–, psychologist–, or psychotherapist–patient privilege. The forensic evaluator, however, having been retained by the attorney, is acting as an agent of the attorney in evaluating the party or parties in the legal matter. This legal agency status puts the forensic evaluator under the umbrella of the attorney–client privilege and usually protects privileged information until such time that the evaluator is declared to be a witness at trial. Until that time, most states, especially in civil matters, allow the attorney to prevent access to that attorney's retained expert by opposing counsel, thus best protecting the party's interest should the evaluator's independent opinion not favor the party of the attorney who has retained him or her. Because it would not be a therapeutic relationship, no such potential protection is available if the forensic evaluator were to be retained directly by the party, thereby creating the onus of one's own expert who was hired to evaluate some potential merit to the case instead being used to discredit the retaining side. Because parties, through their attorneys, need to be able to evaluate the merits of their case candidly without such jeopardy, the attorney–work-product privilege covers such trial-preparation use of experts retained by counsel.

The main practice point to be made here is that the logic, the legal basis, and the rules governing the privilege that applies to care providers are substantially different from those that apply to forensic evaluators. Given this, the duty to inform forensic examinees of the potential lack of privilege and the intended use of the examination product is embodied in case law (*Estelle v. Smith*, 1981) and the Specialty Guidelines for Forensic Psychologists (SGFP) adopted by the American Psychology–Law Society (APA Division 41) and the American Board of Forensic

pist's trial that revealed that he had worked for the railroad and had been working out of town every Friday evening in question (Blow, 1995).

Seventh, the need for historical accuracy in forensic evaluations leads to a need for completeness in the information acquired and for structure in the assessment process to accomplish that goal. Therapeutic evaluation, in comparison, is relatively less complete and less structured than a forensic evaluation. Moreover, a patient provides more structure to a therapeutic evaluation than does a litigant to a forensic evaluation. Ideally, a patient and therapist work collaboratively to define the goals of a therapeutic interaction and a time frame within which to realize them. The time frame and goals of a forensic evaluation are defined by the legal rules that govern the proceeding, and once these are determined, the forensic evaluator and litigant are usually constrained to operate within them. To make maximum use of the time available, forensic evaluators usually conduct highly structured assessments using structured interviews supplemented with a battery of psychological tests and forensically oriented history and impairment questionnaires. Certainly the plaintiff is encouraged to describe the events in question, but it is the forensic evaluator's task to establish a preincident baseline of functioning, a complete description of the incidents alleged in the legal complaint, the subsequent areas of resilience and impairment of the plaintiff's functioning, the proximate cause of any impairment, and the likely future functioning of the plaintiff, if necessary, ameliorated or enhanced by any needed therapy.

Eighth, although some patients will resist discussing emotionally laden information, the psychotherapeutic process is rarely adversarial in the attempt to reveal that information. Forensic evaluation, although not necessarily unfriendly or hostile, is nonetheless adversarial in that the forensic evaluator seeks information that both supports and refutes the litigant's legal assertions. This struggle for information is also handled quite differently by each expert: The therapist exercises therapeutic judgment about pressing a patient to discuss troubling material, whereas a forensic evaluator will routinely seek information from other sources if the litigant will not provide it or to corroborate it when the litigant does provide information. In the extreme, when presented with excessive underreporting or overreporting of critical information, the forensic evaluator might even decide that the litigant is dissembling.

Ninth, consider the goals of each of these relationships. Therapy is intended to aid the person being treated. A therapist–patient relationship is predicated on principles of beneficence and nonmaleficence—doing good and avoiding harm. A therapist attempts to intervene in a way that will improve or enhance the quality of the person's life. Effective treatment for a patient is the reason and the principal defining force for the therapeutic relationship. According to the Hippocratic oath, "Into whatever house I enter, I will do so to help the sick, keeping myself free from all intentional wrong-doing and harm. . . ." Similarly, according to the ethical principles of psychologists, "Psychologists seek to contribute to the welfare of those with whom they interact professionally. . . . [They attempt] to perform their roles in a responsible fashion that avoids or minimizes harm" (APA, 1992, p. 1600).

Forensic examiners strive to gather and present objective information that may ultimately aid a trier of fact (i.e., judge or jury) to reach a just solution to a legal conflict. A forensic examiner is obligated to be neutral, independent, and honest, without becoming invested in the legal outcome. A forensic evaluator advocates for the findings of the evaluation, whatever those findings turn out to be. Thus, the results of a forensic examination may well be detrimental to the legal position of an examinee (American Psychiatric Association, 1984) and contrary to basic therapeutic principles.

Tenth, the patient–litigant is likely to feel differently about expert opinions rendered by therapists than those rendered by forensic experts. Consider the role of judgment in therapeutic relationships. There is a robust, positive relationship between the success of the therapist–patient alliance and success in therapy (Horvath & Luborsky, 1993). To develop a positive therapist–patient alliance, a therapist must suspend judgment of the patient so that the therapist can enter and understand the private perceptual world of the patient without doing anything that would substantially threaten that relationship. Indeed, some believe that even a posttherapy disturbance of this therapeutic alliance may cause serious harm to a patient; hence many advocate substantial limitations on personal relationships between former patients and their therapists.

In contrast, the role of a forensic examiner is to assess, to judge, and to report that finding to a third party (attorney, judge, or jury) who will use that information in an adversarial setting. To assess, a forensic examiner must be detached, maybe even skeptical, and must carefully question what the litigant presents. Because a forensic psychologist or psychiatrist has not engaged in a helping relationship with the litigant, it is less likely that his or her judgment-laden testimony would cause serious or lasting emotional harm to the litigant than would that of the psychologist or psychiatrist who has occupied a therapeutic role.

Waiving the Dual-Role Conflict

These role differences are not merely artificial distinctions but are substantial differences that make inherently good sense. Unless these distinctions are respected, not only are both the therapeutic and forensic endeavors jeopardized for the patient–litigant but as well the rights of all parties who are affected by this erroneous and conflictual choice. Unlike some conflicts of interest, this role conflict is not one that the plaintiff can waive, because it is not the exclusive province of the plaintiff's side of the case. The conflict affects not only the plaintiff but also the defense and the court. This conflict not only poses therapeutic risks to the patient–litigant but also risks of inaccuracy and lack of objectivity to the court's process and to all of the litigants.

Existing Professional Guidelines

On the basis of these concerns, both psychological and psychiatric organizations have sought to limit these situations when dual functions are performed by a single psychologist or psychiatrist. In increasing detail and specificity, professional organizations have discouraged psychologists and psychiatrists from engaging in conflicting dual professional roles with patient–litigants. As the Ethical Guidelines for the Practice of Forensic

patient–litigant who expected the therapist to be as successful and partisan an expert witness as he or she was a therapist. The argument would follow that the therapist should have reasonably known that the patient would be less likely to disclose certain information knowing that a third person would be made aware of, and potentially use, the information to the detriment of the discloser and, therefore, the therapist should have warned the patient of that potential consequence not just before the therapist changed roles but also before therapy (and the disclosures) even began. It is similarly likely that most people would choose to disclose more information with less self-censorship in psychotherapy than in forensic examinations. Once this information has been disclosed in therapy, and the therapy process then becomes the basis for forensic testimony by the therapist, this then places the otherwise innocuous information into a different context and makes it more likely that this disclosure will be used to the detriment of the patient (Shuman & Weiner, 1987).

Where Then Should the Line Be Drawn?

As stated earlier, psychologists and psychiatrists may appropriately testify as treating experts (subject to privilege, confidentiality, and qualifications) without risk of conflict on matters of the reported history as provided by the patient; mental status; the clinical diagnosis; the care provided to the patient and the patient's response to it; the patient's prognosis; the mood, cognitions, or behavior of the patient; and any other relevant statements that the patient made in treatment. These matters, presented in the manner of descriptive "occurrences" and not psycholegal opinions, do not raise issues of judgment, foundation, or historical truth. Therapists do not ordinarily have the requisite database to testify appropriately about psycholegal issues of causation (i.e., the relationship of a specific act to claimant's current condition) or capacity (i.e., the relationship of diagnosis or mental status to legally defined standards of functional capacity). These matters raise problems of judgment, foundation, and historical truth that are problematic for treating experts.

When faced with issues that seem to fall between these guideposts, it is useful to ask whether each opinion is one that could or should have been reached in therapy. Thus, if the legal system did not exist, would therapists be expected to reach these sorts of conclusions on their own? Would doing so ordinarily be considered an aspect of the therapy process? In doing so, would the opinion be considered exploratory, tentative, and speculative, or instead as providing an adequate basis for guiding legal action outside of therapy? Is the therapist generating hypotheses to facilitate treatment or is he or she reasonably scientifically certain that this opinion is accurate? Is it based on something substantially more than, "My patient said so," "My patient would have no reason to lie," or "My patient would not lie to me"?

Conclusion

Psychologists, psychiatrists, and other mental health professionals have given and received criticism about the use of expert witnesses whose partisanship appears to overwhelm their professionalism. Engaging in conflicting therapeutic and forensic relationships exacerbates the danger that experts will be more concerned with case outcome than the accuracy of their testimony. Therapists are usually highly invested in the welfare of their patients and rightfully concerned that publicly offering some candid opinions about their patient's deficits could seriously impair their patient's trust in them. They are often unfamiliar with the relevant law and the psycholegal issues it raises. They are often unaware of much of the factual information in the case, and much of what they know comes solely from the patient and is often uncorroborated. What they do know, they know primarily, if not solely, from their patient's point of view. They are usually sympathetic to their patient's plight, and they usually want their patient to prevail.

By failing to recognize the inherent limitations of their work as therapists, as well as the conflicting therapeutic and forensic roles, psychologists, psychiatrists, and other mental health professionals risk harm to their profession, their patients, and the courts. Although therapists frequently enter the forensic arena in their efforts to help, these efforts may not only put therapists in ethical difficulty but may also neutralize the impact both of their testimony and their work as therapists. Therapists need to acknowledge the limits of what they can accurately and reliably say on the basis of therapeutic relationships. Although it is difficult, when asked psycholegal questions, therapists must be willing to testify "I cannot answer that question given my role in this case," "I do not have an adequate professional basis to answer that question," "I did not conduct the kind of evaluation necessary to reliably answer that question," "I can only tell you what I observed," or "I can only tell you what my patient told me." No matter how laudable their motives might be, therapists who venture beyond these limits and into the arena of psycholegal opinion are deceiving themselves and others. Engaging in an irreconcilable role conflict and lacking an adequate professional basis for their testimony, they can be neither neutral, objective, nor impartial.

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BIOETHICS and ARMED CONFLICT

MAPPING THE MORAL DIMENSIONS OF MEDICINE AND WAR

by MICHAEL L. GROSS

Medical ethics in times of war are fundamentally different from those in times of peace. War brings military and medical values into conflict, often overwhelming other moral obligations, such as a doctor's charge to relieve suffering, in the face of military necessity.

Medical ethics in time of armed conflict are identical to medical ethics in time of peace," declares the World Medical Association.[1] Were this the case, wartime and peacetime medicine would turn on the same principles and present similar dilemmas. But war fundamentally transforms the major principles and central issues that engage bioethics. A patient's rights to life and self-determination contract; human dignity strains under the barrage of military necessity; and the interests of the state and political community may outweigh considerations of patients' welfare. Also, actors and interests multiply. Combatants and noncombatants, enemies and allies, states and individuals, citizens and soldiers, prisoners of war, the wounded and the dying, those who can return to combat duty and those who cannot—all of these litter the battlefield.

Armed conflict augments the general principles of bioethics with those peculiar to the conduct of war. For instance, states are obliged to recognize noncombatant immunity, minimize collateral damage, and adhere to a principle of proportionality when fighting threatens to take the lives of civilians and destroy their property. If difficult bioethical dilemmas arise when fundamental moral principles conflict, war adds novel dimensions of its own, as competing bioethical principles must contend not only with one another, but also with the overriding "reason of state" and military necessity that animate any issue of military ethics and may overwhelm other fundamental moral obligations.

Medical ethics in war are not identical to medical ethics in times of peace. Moreover, the nature of war is itself changing as conflicts between nation-states and sub-state actors—guerillas, insurgent ethnic

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right to medical care is a function of the threat they pose. Deprived of their right to life, enemy combatants have no intrinsic right to medical care. Once wounded and no longer a threat, however, they regain their right to life and to medical care. This is the moral significance of *hors de combat* (literally "out of combat"), the special status accorded combatants who are no longer a threat. Yet once wounded enemy soldiers recover sufficiently to pose a threat, their status reverts again to that of enemy combatant.

If the enemy's right to medical treatment is contingent upon the threat they pose, the right of one's own wounded soldiers to receive medical care is contingent upon their "salvage value"—that is, the likelihood that they will return to duty. "Salvage," a criterion of medical care unique to war, largely replaces "quality of life."[3] During war, medical personnel do not treat individual soldiers as discrete patients, but as components of a fighting force, a living collective entity. To maintain this force, medical personnel bear an obligation to salvage soldiers and return as many to duty as quickly as possible. Salvage speaks to a specific and *objective* measure of quality of life distinct from the patient's own, subjective evaluation. Salvageable soldiers may not invoke quality of life to refuse treatment, however painful or onerous, if it will return them to military duty. Those beyond salvage, on the other hand, may not appeal to any right to life to secure medical care when resources are scarce. Combatants who are critically wounded and unlikely to return to duty revert to a noncombatant status and lose their privileged claim to scarce medical resources.

War significantly restricts noncombatants' rights as well. Although civilians are generally immune from the ravages of combat, they remain vulnerable to "collateral harm," that is, to unintended but proportionate harm that noncombatants suffer as the unavoidable outcome of a legitimate military operation. This is the original context of the much-vaunted doctrine of double effect, which prohibits adversaries from intentionally harming noncombatants.[4] Though it is subject to considerable controversy and conflicting interpretation, the doctrine subordinates a noncombatant's right to life, and access to medical care, to the imperatives peculiar to war, most notably those concerning military necessity and scarcity of resources.

In the final analysis, each set of actors—enemy wounded, unsalvageable friendly soldiers, and civilians—has a fundamentally different claim to medical treatment contingent on the threat they pose, their salvage value, and military necessity, respectively. Further, the status of each actor is not stable, and constant shifting from one status to another plays havoc with medical ethics.

During war, neither combatants nor noncombatants enjoy the same right to life as ordinary patients. Moreover, the state has a life of its own and will wage war to preserve its right to life and common good. Sometimes the common good reflects the welfare of many citizens, but during war the state rarely sacrifices a few lives to save many. Instead, it sacrifices the lives of many to save some intangible national asset that embodies its common vision of the good life and the collective goods that it believes are worth saving.

Autonomy and Self-Determination in Medicine and War

As ordinary citizens, patients command the right of political and medical self-determination. The former embraces such commonly accepted political rights as representation, movement, and free speech, while the latter encompasses the well-known principles of autonomy and patient self-determination: informed consent, privacy, and confidentiality. War complicates and attenuates these principles. Regardless of a nation's state of war, military service limits, if not alters, the nature of autonomy. Autonomy no longer denotes "self-rule"—that is, rule of one's self for the good of oneself—for the good of the self is not a concern of anyone in the military. Rather, autonomy gives way to benign paternalism as others (officers, for example) rule one's self for the good of the state and its armed forces.

As a consequence, civil liberties—be they freedom of speech, movement, or assembly—face distinct limits, and autonomy in medical decisionmaking largely disappears. Informed consent, confidentiality, and privacy are all curtailed, and as a result, bioethical questions largely settled during peacetime emerge with renewed vigor during war.

Noncombatants find that war tears their liberties apart in a similar manner. During war, nations will often abridge civil liberties, including the rights of free speech, assembly, and representation, to safeguard national security and protect the state's sovereignty and territorial integrity. The patient rights of noncombatants, on the other hand, should remain secure and intact. An occupying power, for example, must provide medical care to civilian populations under its control. Exigencies may occasionally prevent this, but there is nothing to indicate that military medical personnel are relieved of their duty to guarantee informed consent, privacy, and confidentiality. On the contrary, developments since World War Two render it imperative to take particular care with the medical rights of occupied peoples to prevent the kind of abuses that characterized Nazi medical experimentation. This, of course, was the intent of the Geneva Conventions and the post-war Nuremberg Code.[5] These prohibit medical experiments contrary to a person's medical interests. Interestingly enough, wartime medicine brings the principles of autonomy and self-determination to the fore far more urgently than peacetime medicine. The same is true for human dignity and self-esteem.

war or adopting various tactics to wage war. Military necessity functions within particular moral parameters that limit the ends and means of war. Nevertheless, military necessity retains a distinct if not superior status, if only because most individuals gladly weigh the interests of state above their own. Military necessity, therefore, joins the pantheon of other principles that guide medicine and war and contributes to the peculiar dilemmas that characterize bioethics during armed conflict.

Dilemmas of Bioethics during Armed Conflict

During armed conflict, bioethical dilemmas arise in several overlapping settings. First, they may arise in either caregiving or non-caregiving—that is, non-healing—situations. Caregiving dilemmas are the familiar ones; they arise as medical personnel provide individual patients with medical care and confront conflicting bioethical imperatives that may impinge on patient rights. Non-caregiving dilemmas are peculiar to war and arise as physicians are asked to contribute their expertise to the practice of war and the development of weapons systems rather than healing the sick or injured.

Second, dilemmas may arise in both conventional and unconventional armed conflicts. Conventional war denotes relatively symmetrical conflicts between sovereign nation states wielding modern armies and fighting according to the war conventions and laws of armed conflict embodied in the Hague and Geneva conventions.[10] Conventional war, however, has largely disappeared from the international scene, replaced in recent years by fierce ethnic or religious rivalries and asymmetrical conflicts between states and sub-state actors, or between solely sub-state actors. Taking note of the changing nature of warfare, the international community revised the 1949 Geneva Conventions in 1977 to regulate so-called "CAR conflicts," or wars fought by guerillas and insurgents against "colonial, alien, and racist" regimes that dominated the post-war period. The 1977 Protocols extended combatant status to guerillas and irregular forces who, while part of a loosely organized military force, are required neither to wear uniforms nor to carry their arms openly at all times. Civilians also gained additional protections from occupying powers.

These changes created some unforeseen consequences. On the one hand, adversaries are obligated to protect civilian interests to an extent not previously required. On the other, lack of identifying insignia, coupled with the ease with which combatants can shed their status and attain civilian protection simply by leaving the battlefield, has made it difficult to observe the distinction between combatants and noncombatants so necessary for the latter's protection. At the same time, many belligerents are no longer content to disable their enemies, but employ whatever means seem necessary to displace entirely both military and civilian populations from disputed territory. This sometimes encourages adversaries, usually the weaker, to embrace terror, consider unconventional weapons, and abuse civilian protections by masquerading as civilians, placing their armed forces in close proximity to civilian populations, or using medical facilities for hostile purposes. Wars in the former Yugoslavia, Central Africa, and the Middle East typify these conflicts. In these conflicts, the difficulty of identifying combatants and handling the perfidious tactics they sometimes employ seriously hinders the implementation of humanitarian law in general, and medical ethics in particular.[11]

Conventional and unconventional war engender both caregiving and non-caregiving dilemmas for medicine. Patient rights in time of war, medical neutrality, and unconventional weapons development exemplify some of the complex issues that bioethics faces during armed conflict.

Caregiving Dilemmas in Conventional War: Patient Rights

Informed consent, confidentiality, and the right to die are patient rights anchored in personal autonomy and the right of self-determination. If war abridges autonomy, these subsidiary rights should narrow significantly. Consider three examples:

- In 1990 and 1998, the U.S. Department of Defense weighed the use of investigational chemical compounds to protect combatants against the threat of chemical and biological warfare. Inasmuch as these drugs were not standard care, many observers demanded that the army obtain informed consent. Arguing that this was not feasible, the Defense department prevailed with an appeal to military necessity.[12]

- The term "medical ethics" appears in a curious context in the 1977 Protocols as lawmakers grapple with violations of confidentiality and a physician's duty to "denounce," that is, turn in, enemy patients to the authorities.[13] The framers seem to have in mind the dilemma facing a physician who unknowingly treats an injured guerilla only to discover his identity during treatment. In a fictionalized account, Pearl Buck applauds a Japanese doctor who treats and then releases an injured American serviceman rather than condemn him to the horrors of a Japanese POW camp.[14] Some people would be less pleased, I imagine, should an American doctor treat and release a suspected Iraqi insurgent.

- Combatants have no right to refuse medical treatment and, by extension, no right to die. But what of critically wounded soldiers who cannot return to duty? If salvage guides medical care and unsalvageable soldiers revert to ordinary civilians, then should not a

when they are no longer militarily useful.

Caregiving Dilemmas during Unconventional War: The Problem of Neutrality

Since the founding of the Red Cross, international law has consistently protected medical personnel and facilities. A number of norms govern these practices and, depending on battlefield conditions, guarantee timely evacuation for the wounded and blanket protection for the facilities that treat them, such as mobile surgical units, fixed medical facilities, and hospital ships. Ordinarily, these rules are not problematic. Compliance is widespread; violations are quickly condemned. Changes in warfare, however, threaten these protections and create new dilemmas for military commanders.

Consider the conflict between Israel and the Palestinian militants. Obligated by the Geneva conventions to provide medical care to an occupied people, expeditiously evacuate the wounded from the battlefield, and protect medical personnel and ambulances, Israel has found that the threat of terror and the inability to clearly distinguish combatants from noncombatants has made these obligations sometimes difficult to fulfill. Blockading Palestinian cities in order to prevent terrorism disrupts access to medical care as the sick are detained at check posts and ambulances are stopped and searched. During combat, Israelis have attacked ambulances, killed medical personnel, and obstructed the evacuation of wounded militiamen and civilians—as Palestinian guerillas have booby trapped the wounded, used ambulances to transport men and matériel, and taken refuge in hospitals.[16]

The dilemmas these situations pose turn on the army's duty to prevent terror attacks and shield civilians from harm. There are also two countervailing duties: the obligation to protect neutral medical facilities, and the duty to avoid harming the sick and injured. In one sense, the very nature of neutrality eases the tension of fulfilling these two protocols. Medical neutrality grew from convention, that is, from mutual self-interest and reciprocity, rather than any deontological principle, so that any violation by one side may scuttle the convention and leave the other side to violate neutrality.[17] This turns the decision to remain neutral into an assessment of the relative costs and benefits each side can expect from violating neutrality. Hampered by uncertainty, however, this assessment is difficult to make. If one ambulance is used to transport arms or terrorists, what are the chances another will be used in the same way? Human rights activists call on Israel to show restraint because the probability is not high. In fact, most ambulances are utilized for their intended purpose. Israeli responses echo rational choice: under uncertainty, the odds of abuse are even. And if the odds are even and the potential harm posed by terrorism pales next to the harm a single patient in an ambulance may suffer, then simple utility demands stopping each and every one. Palestinians complain that harm accumulates to their detriment; Israelis fear that the next ambulance may carry a bomb. In this environment, civilians and wounded suffer as medical care is disrupted in precisely the way the Red Cross hopes to prevent. Here we see how clear and traditionally honored guidelines are upended by insurgency warfare, creating ethical challenges for which international law and custom offer no ready solution.

Non-Caregiving Dilemmas during Unconventional War: Chemical and Biological Warfare

Non-caregiving dilemmas present special problems as medical personnel are called upon to use their expertise in a way that causes death and injury. In some nations, physicians continue to find themselves asked to develop weapons for chemical and biological warfare (CBW) despite the international ban on these weapons and the WMA's declaration that it is "unethical for the physician, whose mission is to provide health care, to participate in the research and development of chemical and biological weapons."[18] Most nations honor the international conventions and WMA declaration prohibiting CBW. However, some states do not. Moreover, the WMA overlooks the very difficult issue of nonlethal chemical weapons. Consider the following two cases:

- None of the parties to the current conflict in the Middle East have ratified the international conventions against chemical and biological weapons, and although there is no similar ban on nuclear weapons, only Israel commands the resources to maintain a nuclear arsenal. This has left Egypt, for example, to pursue the "poor man's" option of deploying chemical and biological weapons to deter Israel's nuclear threat.[19] What is an Egyptian physician to do when asked to participate in his nation's CBW program?

- "There is a fundamental ethical dilemma for doctors," writes an official of the International Red Cross. "The development of this new generation of [nonlethal] weapons incorporates knowledge from the remarkable advances made in medical science; two examples are calmatives [compounds that depress or inhibit the function of the central nervous system] and eye attack lasers. . . . *The medical community must guard against use of its knowledge for the purposes of weapon development.*"[20]

Non-caregiving dilemmas such as these are unique because they upend the conventional paradigm that guides medical practice, and within which some aspect of a patient's welfare is always a primary consideration. In these cases, there are no patients, only ordinary human beings who are harmed by one's deliberate actions

other professions that serve different human needs and that may fall before reason of state during war. The "laws of humanity," in contrast, invoke humanitarian law and respect for human rights. They are inviolable insofar as they do not conflict with one another, and, in spite of the tendency sometimes to conflate the laws of humanity and medicine's professional duty of beneficence, the two are not synonymous. Preserving this distinction is important. While one would not expect a physician or anyone else to use his or her knowledge contrary to the laws of humanity, there is sometimes room to ask whether any individual, physicians included, may violate another person's "bodily and mental health." This is the question we all face in the shadow of armed conflict.

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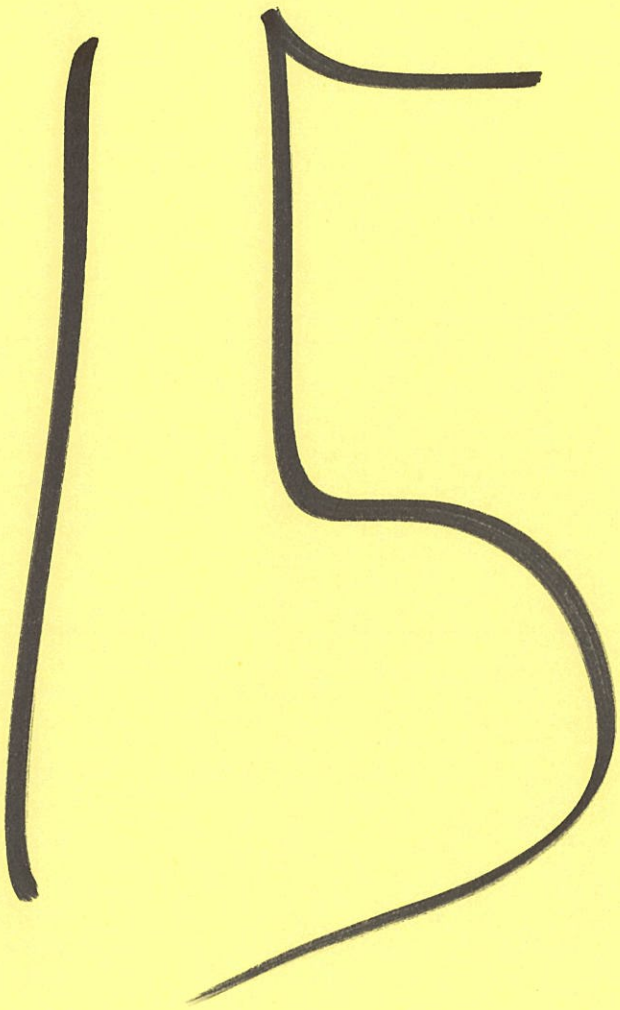

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DOCTORS IN THE DECENT SOCIETY: TORTURE, ILL-TREATMENT AND CIVIC DUTY

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ABSTRACT

How should physicians act when faced with corporal punishment, such as amputation, or torture? In most cases, the answer is clear: international law, UN resolutions and universal codes of medical ethics absolutely forbid physicians from countenancing torture and corporal punishment in any form. An acute problem arises, however, in decent societies, but not necessarily liberal states, that are, nonetheless, welcome in the world community. The decent society is often governed, in whole or in part, by religious laws, and while these states abridge various human rights they are peace loving, generally tolerant, and offer their citizens wide avenues for political participation. Under these circumstances the prohibition against corporal punishment and torture weakens, often compelling physicians to participate. This is true in two cases. In Rawls' hypothetical nation of Kazanistan, Islamic law is the order of the day, and amputations and corporal punishment play an integral part in the execution of traditional Islamic justice. In Israel, torture is sometimes used to elicit the information needed to thwart impending terror attacks. In each case, a physician's participation is essential. In light of the near universal condemnation that accompanies torture and corporal punishment, physicians can only appeal to norms anchored in collective well-being and concern for life that override respect for human dignity in these societies. Western societies have consistently rejected this reasoning, but it is part and parcel of life in the decent society.

INTRODUCTION

Physicians have an age-old duty to serve the welfare of their patients. Citizens, in turn, are bound to serve the welfare of their state and society. In liberal societies, professional and civic duties

the survival of the political community overrides these rights. 'Overridden' rights do not disappear but soon resurface once the threat is removed, and demand contrition together with compensation for those affected.

Decent societies, on the other hand, need attach no special status to basic human rights, and two examples suggest that decent societies may interpret these rights to permit some forms of ill-treatment and corporal punishment. First, the tolerant, benevolent Islamic nation Rawls describes as the paradigm decent society does not, indeed cannot, preclude a criminal justice system that requires amputating the limbs of convicted criminals. This is certainly cruel punishment to the framers of the UN declaration,[3] but entirely justified according to the religious law that can prevail in a decent, Islamic society. Second, some decent nations continue to practice torture or other forms of physical pressure during interrogation. In Israel[4] for example, torture is illegal but defensible under certain conditions of war and public emergency, a practice entirely proscribed by international law, UN convention and medical ethics.

These two examples, one theoretical and one real, bring a physician's civic and professional duties to the fore. Amputation and torture require a physician's assistance but neither can be performed without harming one's patient. How should physicians in these nations behave? The discussion addressing this question proceeds in two parts. Part one describes cruel punishment and torture in the decent society. Part two explores the role Islamic and Israeli physicians play in each nation and the moral dilemmas they face. In each case there are some institutions and practices which are so urgent that a physician's duty to care for his patient is overridden by his duty to the state.

[3] See, for example: *The Report of the Special Rapporteur on Torture, UN High Commissioner for Human Rights* (E/CN.4/1997/7), 1997, 'urging Governments of States which maintain the penalty of amputation to take appropriate measures to provide for other punishment consonant with Article 5 [of the Universal Declaration of Human Rights] (www.unhchr.ch). See also: N.S. Rodley. 1999. *The Treatment of Prisoner's Under International Law.* Oxford. Clarendon Press: 313–314.

[4] Whether Israel is a decent or liberal society is a question that I will not consider in any detail. Israel defines itself as a 'Jewish-democratic' state, a fusion that precludes a clear label of 'liberal.' But 'decent' and 'liberal' are not necessarily two distinct categories but end points on a continuum. As Israel struggles to define its Jewish and democratic nature, it has yet to find its place on this continuum.

Traditional Islamic law, the shari'a, comprises Hudud offences, or acts against God. Punishment is non-discretionary and specifically prescribed in the Koran. Of the Hudud offences, theft is particularly noteworthy. It does not include every sort of common theft but is limited to the removal of certain types of valuable personal property by 'stealth' from a place of safekeeping. The standard of proof is particularly rigorous, demanding a confession or two unimpeachable witnesses.[7] Once satisfied, punishment is unusually strict: amputation of the hand at the wrist and, for subsequent offences, of the foot at the ankle by an licensed physician:

> The condemned person is brought, the verdict is read loudly and the arm is stretched on the surface of a regular table with the body of the condemned person turned backward. In a quick move, a professional executioner (*in the presence of at least one male physician*) exerts a strong pressure, pulling the hand away from the wrist and severing the limb at the joint with a sharp knife. At that moment, the physician intercedes to stop the bleeding and bandage the wrist.[8]

The role of the physician varies: sometimes he performs the amputation, other times he provides follow-up medical care.[9] In either case, his presence is mandatory.

Is this cruel and inhuman punishment, proscribed by any attention afforded to human dignity? Local officials do not think so. In Taliban Afghanistan, officials told the UN Special Rapporteur that amputation preserves 'security and peace', 'prevents the recurrence of theft' and protects 'human rights and larger interests of the population.'[10] The scholarly argument, detached from

[7] Admissible confessions must be voluntary, detailed, and unequivocal, 'indicating the confessor's awareness of what he or she has done and reaffirming an understanding of the legal consequences of the confession.' Suspects may also withdraw their confession at any time requiring judges to implement other rules of evidence or try the suspect on different charges (S.S. Souryal, D.W. Potts & A.I. Abdullah. The Penalty of Hand Amputation for Theft in Islamic Justice. *Journal of Criminal Justice* 1994; 22: 249–65, at 262.

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dhimmis, a policy not excluded by the decent society and even extolled by Rawls.[15] But even the most gracious description of their status is a liberal nightmare: non-Muslims enjoy religious freedom and limited representation but are disqualified from political office, may not bear arms, cannot testify against Muslims, must sometimes wear distinctive dress, cannot build their houses higher than Muslims and have limited legal rights.[16]

Although dhimmi status is acceptable, not every religiously tolerable policy is decent. Slavery is an important example, particularly as some argue against corporal punishment by comparing it to slavery. Although both once enjoyed social support and legal sanction, slavery has fallen into disfavour in modern times precisely because it offends human dignity, the very same principle that should require us to forbid corporal punishment.[17] But not every affront to human dignity is indecent. The status of the dhimmi clearly shows this. While slavery, on the other hand, might have been accepted by older religious societies, it is rejected by the decent society because it violates the condition of universal participation in its limited form of group representation.

The underlying intuition is not some weak form of self-determination or human dignity, but rather paternalism. To be decent, the decent society must care for the welfare of its citizens and consider the interests of each group. To do this, each individual belongs to a group that is both recognised and represented in the political system. Slaves, *ipso facto*, are not represented in this way. In fact, they are not represented at all. Decent regard for the interests of all individuals precludes slavery and egregious discrimination (non-representation of women, for example). A policy cannot be decent unless it confers benefits important to all members of Islamic society and derives its legitimacy from a political and criminal justice system that represents all the groups it serves.

Nevertheless, Western observers take a dim view of amputation and other forms of corporal punishment. The reasons are not difficult to discern. Human dignity is the cornerstone of liberal society and the UN declaration of human rights protects self-determination and bodily integrity while prohibiting abuse and ill-treatment. These rights, by definition, cannot be subordinated to some larger social good for no such good exists unless these

[15] Rawls, *op. cit.* note 1, p. 76, note 17.
[16] Lippman et al., *op. cit.* note 6, pp. 123–124.
[17] BMA, *op. cit.* note 6, p. 97.

all international norms, suggested that Israel set standards for using 'moderate physical pressure.' This includes beating and slapping, forcefully shaking the upper torso causing the neck and head to 'dangle and vacillate rapidly' and excessive tightening of handcuffs. In many cases, suspects are hooded with filthy, opaque sacks, stood spread eagle or seated in painful, contorted positions on low chairs, and subjected to powerfully loud music and sleep deprivation.[19] The psychological and physiological sequelae of these interrogation techniques are often traumatic.[20]

The commission's position rests on several salient points: terrorism threatens the existence of the State of Israel, it cannot be subdued without some measure of physical pressure and moderate physical pressure is distinct from torture.[21] Moderate physical pressure, moreover, is limited to interrogation, i.e., the extraction of information. It is not intended to punish political adversaries nor deter others from opposing the regime. Just as interrogation does not presuppose guilt, neither do extraordinary interrogation methods. Hence there is no necessary presumption of guilt, only the presumption of holding critical information. These differences distinguish 'interrogational torture' from 'terroristic torture'; the latter designed to suppress political opposition and brutalise large segments of the population.[22]

None of these considerations, however, legalise torture in the eyes of the international community. Neither the severity of physical pressure nor the unique circumstances surrounding its use is relevant. Article 3 of the UN Declaration Against Torture is unequivocal on this point: 'no State may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment; exceptional circumstances such as a state of war or threat of war, internal political instability or other public emergencies

[19] *Public Committee Against Torture in Israel v The State of Israel*. 1999. HC 5100/94, para 8–15.

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[21] Landau Commission. Commission of Inquiry into the Methods of Investigation of the General Security Service Regarding Hostile Terrorist Activity. *Israel Law Review* 1989; 2: 146–188. The US State Department defines terror as 'any premeditated activity using force against noncombatants for political means.' While the term itself is subject to alternative definitions, the victims' innocence is central to most discussions (see: C.W. Kegley, Jr. 1990. The Characteristics of Contemporary International Terrorism. In *International Terrorism: Characteristics, Causes, Controls*. Charles W. Kegley, Jr., ed. New York. St Martins Press: 11–26.)

[22] See: H. Shue. Torture. *Philosophy and Public Affairs* 1978; 7: 124–143.

Palestinian unrest intensifies.[25] But the court did not unequivocally ban torture in any case. Recourse to dire necessity effectively permits torture in certain cases and the State Prosecutor has announced that 'as long as interrogators act *reasonably* they will not be tried on criminal or disciplinary charges for their actions even if jurists define these actions as unjustified.'[26] An investigator acting reasonably will only use moderate physical pressure as a last resort to elicit information from suspects sitting on ticking bombs.

The 'ticking bomb' argument is not airtight nor without opponents. While many agree that mitigating circumstances left largely to the assessment of the investigators may justify torture in rare instances without subverting the criminal justice system,[27] others want to ban absolutely the use of moderate physical pressure. Ineffective and a gross affront to human dignity, any form of physical pressure is the first step down a slippery slope threatening the rights of innocent individuals and leading inevitably to insecurity and egregious discrimination. As such, torture is only permitted under the most exacting conditions, aimed only at suspects who will, with utmost certainty, provide information absolutely necessary *and* sufficient to defuse a bomb. Inasmuch as there is never any such assurance, torture is always prohibited.[28]

It is beyond the scope of this paper to examine the cogency of all these arguments.[29] However, it is important to see that any position that absolutely bans torture does so, primarily, because it weighs human dignity over human life. While determining the relative weight of these two values presents a common dilemma,

[25] See: Public Committee Against Torture in Israel (PCATI). 2001. *Breaches in the Defense: Torture and Ill Treatment during GSS [General Security Services] Investigations Following the Verdict of the High Court of Justice, 6 September 1999–6 September 2001*. Jerusalem. PCATI. In July 2002 Israeli newspapers reported that the GSS used extraordinary means of interrogation including moderate physical pressure and sleep deprivation in 90 'ticking bomb' cases (*Yidiot Aharonot* July 25, 2002).

[26] News Item, *Haaretz* 15 February, 2001 (emphasis added).

[27] Shue, *op. cit.* note 22; S.H. Kadish. Torture the State and the Individual. *Israel Law Review* 1989; 23: 345–356. M.S. Moore. Torture and the Balance of Evils. *Israel Law Review* 1989; 23: 280–344.

[28] M. Kremintzer. The Landau Commission Report – Was the Security Service Subordinated to the Law, or the Law to the 'Needs' of the Security Service? *Israel Law Review* 1989; 23: 216–279. B'tselem. 2000. *Position Paper, Legislation Permitting Physical and Psychological Pressure in the Investigation of the General Security Services* (GSS). Jerusalem. B'tselem. D. Statman. Question of the Moral Absoluteness of the Prohibition on Torture. *Mishpat vMemshal* (Hebrew) 1997; 4: 161–197. Human Rights Watch/Middle East. *op. cit.* note 20.

[29] For a detailed discussion see: M.L. Gross. Forthcoming. Torture in a Democracy: Death and Indignity in Israel. *Polity*.

tial for safeguarding the greater good, what role, then, should physicians play? We know the role they *do* play. Islamic physicians continue to supervise amputations in nations that strictly adopt shari'a law, and the hypothetical Islamic decent society has no reason to legislate any differently. In Israel, physicians are present in interrogation centres to certify a prisoner's health before and after interrogation, and may actually certify a suspect's fitness for various forms of questioning.[31] Doctors play a crucial, facilitating role that would allow them to hamper an investigation, seriously obstruct the entire system or, in the very least, compile documentation of abuse should they choose.

Whether physicians should obstruct the system is a question of moral and practical importance. Human rights groups charge compliant physicians with passive acquiescence to torture.[32] The Israel Medical Association (IMA), on the other hand, stands firm in face of criticism that its members violate the basic duties of medicine. Before the 1999 Israeli Supreme Court ruling, the IMA denounced torture but tacitly supported interrogations restricted to using moderate physical pressure. By 1999, the IMA welcomed the Court's ban on torture hoping that the 'dark days' of moderate physical pressure would not return, but again acknowledged support for physical measures – as distinct from torture – in 'ticking bomb' cases.[33] The distinction between physical measures and torture is facile and legally irrelevant. While some jurists draw an analytical distinction between degrading treatment and torture, both are prohibited by international law, convention and codes of medical ethics.[34] While Israeli doctors are not the only confused ones, the IMA's underlying message is clear: collective well-being and state law supersede a physician's responsibility to his patient's individual well-being.

A physician's social responsibility to the entire body politic is the crux of the matter. Like the Islamic doctor who is party to an

[31] Based on prison medical forms found circulating in 1993, there were charges that Israeli doctors certify a prisoner's fitness to endure certain forms of physical pressure such as chaining, hooding and prolonged standing during interrogation. Condemned by the Israel Medical Association, these medical forms were reportedly removed from circulation (Human Rights Watch/Middle East, *op. cit.* note 20, pp. 216–219).

[32] The Public Committee Against Torture in Israel (PCATI). 1993. *Dilemmas of Professional Ethics as a Result of the Involvement of Doctors and Psychologists in Interrogation and Torture.* Jerusalem. PCATI: 60–61.

[33] Y. Blachar. Unpressured Physicians. *Haaretz* (Hebrew) 15 November, 1999: 28. See also: Y. Blachar. The Truth about Israeli Medical Ethics. *The Lancet* 1997; 35: 1247.

[34] N.S. Rodley. *op. cit.* note 3, pp. 92, 371–381.

The prohibition is absolute: there are no exceptions whatsoever for any emergency threatening collective well-being. This is reiterated in the UN Declaration against Torture (1975) and the UN Principles of Medical Ethics (1982).

In recent years, re-emergent communitarian concerns and soft paternalism have blunted overriding concern for individual welfare. In some ways the effect is local, as the idea of the 'patient' is expanded to include family and community. From this perspective, the decision to care for a critically ill neonate, for example, might depend upon the financial, social and emotional impact this has on other family members, a factor considered irrelevant if not immoral not long ago. Similarly, hearing-impaired children may be denied cochlea implants in the interests of preserving the integrity of the Deaf community. In other cases the effect is global, pushing beyond the family to society at large. Resource allocation, for example, may demand that we restrict services to the elderly or certain classes of critically ill patients to preserve resources for the entire community.[40] One effect of these developments is to expand the notion of 'do no harm' to include actors and entities beyond the individual patient. This allows physicians to consider the effects of their actions on others. A physician who is part of an interrogation team faced with a ticking bomb may, justifiably, consider the welfare of others beyond his single patient as he tries to decide what to do.

Another outcome of communitarian thinking subordinates indignity to death and social disorder, making it more important to protect life rather than dignity. The physician, therefore, is not automatically required to uphold dignity when it conflicts with human life, whether his patient's or anyone else's. This once easy-to-solve dilemma – 'uphold dignity when it conflicts with human life' – is no longer self-evident and the decent physician may decide otherwise. This leads to a careful reconsideration of liberal ethics as they play out in medicine, politics and law. It begins with blatantly violating a patient's dignity by force feeding him or treating him against his will. It ends as we consider grounds that allow a physician to play a pivotal role in a criminal interrogation that utilises physical force or a criminal justice system that condones

[40] M.L. Gross. Avoiding Anomalous Newborns: Preemptive Abortion, Treatment Thresholds and the Case of Baby Messenger. *Journal of Medical Ethics* 2000; 26: 242–248. D. Callahan. 1990. *What Kind of Life: The Limits of Medical Progress.* Washington. Georgetown University Press. E. Emanuel. 1991. *The Ends of Human Life.* Cambridge. Harvard University Press.

individuals' lives rends the fabric, both bodily and spiritual, of the entire community. This perception spills over into an Israeli patient's rights law that approves of treating a patient against his will when there is a reasonable expectation that treatment will significantly improve his condition. Paternalism and concern for collective well-being demands that the state treat this patient against his express wishes. It is not liberal behaviour, but it may be the decent thing to do.

Decency, irrespective of the larger role of citizenship, allows a physician to violate a patient's civil liberties for a greater good, in this case, the patient's life. This move is justified by communitarian considerations that subordinate the patient's civil liberties to certain community interests that transcend the patient's rights and interests. This opens the door to other communal and collective interests that compel us to consider the physician's duty to do no harm in a wider context.

Collective interests in the circumstances cited take two forms: concern for the immediate safety of a large number of individuals, the case we confront with a ticking bomb; and concern for the long-term welfare of the society at large when strict Islamic law is enforced. The first rests on a straightforward calculation of expected utility and the *prima facie* duty of any human being to bring about more good than harm when this does not entail unreasonable risk to himself. In this case each citizen, including the physician, must consider the harm done to all those affected by his action. If, when faced with a 'ticking bomb', torture can save more lives than would otherwise be the case if it were not used in an interrogation and, if it meets the conditions of necessity outlined earlier, then a physician must do his part during an interrogation. Then the physician, like the interrogator himself, may have to defend himself. He will have to convince his peers that physical force was the least harmful means available to secure a higher moral good, namely, the welfare of innocent people. This possibility, although rare and subject to strict conditions of proof (not unlike the shari'a), is nevertheless a real one. If the interrogator must defend himself, so must the physician. The interrogator cannot be the only one in the dock. Torture requires medical assistance and the decision to use physical force always requires a physician's consent. Doctors, like investigators, are not simply acting under orders. They are part of the decision making process and must later defend themselves in public.

It is important to emphasise that the physician called to assist in an interrogation is not in the same position as a physician asked to perform an abortion or assisted suicide. In these cases, a doctor

disobedients in a liberal society as they subjected public policy to liberal norms. While commendable, it is not incumbent upon the Muslim physician in a decent, hypothetical Islamic society to similarly oppose the law. On the contrary, he faces no predicament when he obeys the law and supervises court ordered amputations.

The Islamic physician's task is more difficult because he faces a collective action problem. Unlike his Israeli counterpart who can see the benefit of torture, the Islamic physician may see no immediate value from his decision to assist in an amputation. On the contrary, the intense pain caused his patient is the direct and avoidable result of the doctor's actions, while the benefit to the public good is diffuse and largely unnoticed. As a result, the Islamic physician faces the dilemma that comes with providing any public good. The benefit from Islamic law is the long-term establishment of a just and decent society. But the increased probability that his act of amputation will benefit Islamic society may not overcome the short-term costs to the physician and his patient. The reflective physician, therefore, cannot think solely in terms of expected utility as his Israeli counterpart, but must further weigh his duty to the decent Islamic state to condone corporal punishment.[46] In either case, whether in the Israeli communitarian state or in the Islamic theocratic state, duties to others reconstitute the liberal physician-patient relationship.

CONCLUSION

The community of nations respects decent societies because they can be good, peaceful, and productive neighbours. To gain entry into the world community, the decent society must be non-belligerent and peace loving. Internally, it must enjoy the support of all its citizens, represent their needs and interests and uphold the rule of law.

The place of human rights in this scheme remains nebulous. Civil liberties including the right to vote, assemble and exercise free speech are not mandatory. While important, these rights are not unconditional and may be temporarily set aside under urgent circumstances. Other rights, in the view of the world community, are non-derogative. These include protections against torture and cruel, inhuman and degrading treatment. While these principles

[46] Duty, particularly religious duty, often provides the 'extrarational' motivation to overcome this kind of free-rider problem. See: M.L. Gross. 1997. *Ethics and Activism: The Theory and Practice of Political Morality*. Cambridge. Cambridge University Press: Chapter 4.

Torture and corporal punishment test a physician's intuitions, his duty to his patient and his obligations to the state. When bioethical norms mirror liberal democratic norms, doctors encounter few difficulties. Unfortunately, norms often diverge from practice and today, in the wake of indiscriminate terror, liberal democratic states are again sitting on the horns of a dilemma that pits life and well-being against dignity. It is not, however, the life and dignity of the same person that is at stake, but the lives of some and the dignity of others. This is a new problem and one where the experience of a hypothetical Islamic society and a Jewish state fighting terror might be helpful.

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FORUM – PSYCHIATRISTS AND THE DEATH PENALTY: SOME ETHICAL DILEMMAS

Comments

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In 1975 a working group from the Regional Office for Europe of the WHO met in Siena, Italy. The subject for discussion was forensic psychiatry. The discussion inevitably embraced ethical matters. One of the important conclusions from the meeting was that 'general medical ethics applied to forensic psychiatry in exactly the same way as they apply to other parts of the medical profession, and, in particular, a forensic psychiatrist should see his first duty as to his patient, and should *not* operate as a part of the state control systems'.

Contemporaneously there were persistent allegations that political dissidents in the Soviet Union were locked up as mentally abnormal and were 'treated' with psychotropic drugs in order to change their opinions [1,2].

The Soviet Union was forced to resign from the World Psychiatric Association for a few years because of this pressure. Eventually the Soviet government allowed western observers to inspect their hospitals. The USA sent an official delegation in 1989. A further visit was conducted in 1991 on behalf of the World Psychiatric Association. This team was chaired by James Birley from the UK and included Loren Roth, the medical leader of the previous US delegation.

Different concerns have led to pressure on the Japanese government [3,4]. From 1968, reports of violence to patients, including patient deaths, began to emerge. In 1984 the director of a Japanese hospital was sent to prison for putting profits before patient care. Totsuka and his group campaigned via the United Nations Commission on Human Rights and in 1988 a new Mental Health Act became law in Japan.

In such ethical matters, many of us look to the USA for support and for leadership. The USA has a remarkable written constitution (the oldest in the world) based on liberal principles and is genuinely democratic. In this context 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 it has cast out from its midst. It is harder still for European doctors to understand a contemporary debate about the involvement of the medical profession in such a process. It is widely assumed that, should the worst happen and capital punishment were reintroduced into western European countries, the medical profession would set its face against such a political catastrophe and not partake in it. Surely, the public would expect nothing less from the medical profession. The public knows that doctors are bound by the ethics of their profession to comfort, to try to preserve life, and to never harm anyone. The privileges, the responsibilities, the status of medical practice, come from a clear understanding that this is what doctors are like, and that if individuals lapse from these high standards they will be, in one way or another, disciplined within their own profession or may be ejected from it.

From the eastern shore of the Atlantic ocean, therefore, the debate which has been going on for some time in the USA and which is so well encapsulated in the Freedman and Halpern article, seems almost incomprehensible. It is difficult to get all the nuances of this debate from afar, and even visits to the USA do not completely clarify the matter as this is essentially an internal American grief. To some extent, non-Americans feel like helpless bystanders hoping that Uncle Sam, or at least Uncle Sam's doctor, will soon come to his senses so that he can join, once again, with the rest of the medical profession in the world to try to defeat the distortions of medicine which can so easily occur when it is hijacked for nefarious purposes.

News is emerging that suggests doctors in China are now active as executioners [5]. It has been reported that one

Freedman and Halpern are thoroughly right in their unequivocal criticism of Appelbaum's twin assertions that (1) psychiatrists judging competency for execution are not practising psychiatry; and that (2) the ethics of medicine as applied to forensic psychiatry should be suited to the needs of the Court. Both assertions are patently illogical, socially deleterious and utterly corrosive to the integrity of medical ethics.

Psychiatry is not defined by the purposes to which we put it. Competency determinations depend on knowledge and methods developed by, and specific to, psychiatry. The Courts do not have this knowledge. That is why they need psychiatric expertise in the first place. Appelbaum's clumsy euphemism, making the psychiatrist a 'forensicist', is a bizarre and transparent distortion of reality to give benediction to an ethically illicit act.

Similarly, the ethics of medicine (and psychiatry as a branch of medicine) is not defined by convenience, the needs of the state or the purposes to which we wish to put medical knowledge. Medical ethics derives from the universal predicament of human illness, from the vulnerability, dependence and exploitability of those the physician attends. The ends of medicine are healing, helping, comforting and curing. Every physician pledges to serve those ends when she or he enters the profession. Being an accomplice in the death of a human being is totally inconsistent with the ends of medicine. No act of law or fiat can change that fact.

Appelbaum's elastic logic invites the usurpation of medical power in the name of politics and ideology, and not primarily in the interest of the patient. Totalitarian states do so with gross abandon; democracies with more discretion. The result, in either case, is to imperil the most vulnerable members of our society.

Physicians must remain the guardians of the moral integrity of the profession and its ethics. Psychiatrists must heed the ethical proscription against assisting in legal executions enunciated by the World Psychiatric Association. In these times, their witness to the integrity of medical ethics is an assurance that some things are not at the disposal of whim, fancy or political power.

Recommended reading

1 Pellegrino ED. Guarding the integrity of medical ethics: some lessons from Soviet Russia. *JAMA* 1995; 273:1622–1623.

2 Pellegrino ED. The Nazi doctors and Nuremberg: some moral lessons revisited. *Ann Intern Med* 1997; 127:307–308.

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Freedman and Halpern should be commended for their dogged efforts to focus professional attention on the ethical ambiguity of forensic psychiatry and, more specifically, on the unique ethical dilemmas raised by medical participation in capital cases. Although I do not agree with their position on evaluations of competence of condemned prisoners, I share many of their concerns.

I want to begin by emphasising that I wholeheartedly agree with Freedman and Halpern about the need for vigilance in maintaining the profession's ethical integrity in the face of political and economic pressures that can undermine public trust in the healing role of the profession. The Nazi experience and the abuses of Soviet psychiatry provide compelling evidence of the dangers to the profession, and to human rights, that arise when the tools of medicine are appropriated to serve the goals of the state. That is why I have joined hands with psychiatrists in the former Soviet Union and other formerly communist nations of central and eastern Europe to help them build the institutional foundations for professional independence, including an autonomous system for promulgating and enforcing ethical norms [1].

I also agree that medical participation in an execution (as by injecting a fatal dose of barbiturates, selecting injection sites, giving technical advice, or monitoring an injection given by someone else) must be unequivocally prohibited. The American Medical Association and the American Psychiatric Association have condemned such conduct and, as far as I know, nobody within the professional community has argued that it is ethically permissible.

It is helpful to identify the ethical principle that underlies the prohibition against medical participation in executions. Clearly, the objection does not simply lie in the fact that the doctor is serving a non-therapeutic role for the legal system: some non-therapeutic roles are ethically acceptable, for example an assessment of disability for the worker's compensation system or an assessment of competence to stand trial for the criminal justice system. (As these observations suggest, the debate about psychiatric involvement in executions is being carried out in the shadow of a broader controversy concerning the ethical foundations of forensic psychiatry. I will return to this problem below.)

Why, then, is medical participation in executions almost uniformly regarded as unethical? The answer lies not in the logic of therapeutic ethics, but rather in the fundamental idea that serving as an agent of the state's punitive apparatus is not an acceptable social role for a doctor.

Having highlighted an area of continuing disagreement, I want to emphasise two points on which I completely agree with Freedman and Halpern. The issue of treating condemned prisoners puts doctors in an ethical bind. The only sensible way out of the dilemma is for the law to require commutation of the death sentences of prisoners who have been found by a court to be incompetent for execution. Also, even if the possibility of execution remains, the psychiatrist responsible for treatment should play no role whatsoever in the process of competence evaluations; as in other contexts, therapeutic and evaluative roles should be completely separated.

I want to close by emphasising, once again, that I applaud Freedman and Halpern for their vigorous efforts to generate ethical discussion of these issues. At the same time, however, I must also note my suspicion that many physicians who condemn execution competence evaluations are either morally opposed to the death penalty, or have deep ethical qualms about forensic psychiatry. For the record, I will note my own opposition to capital punishment. In my experience, lawyers, judges, doctors, and anyone else who participates in the administration of the death penalty inevitably become mired in ethical quicksand. Unfortunately, professional efforts to evade the quicksand tend to erode the rights and interests of defendants and condemned prisoners. The death penalty should be abolished, but as long as it remains in force neither psychiatric assessment of condemned prisoners nor treatment of incompetent ones should be categorically forbidden.

As for forensic psychiatry, I think Freedman and Halpern have mischaracterized the terms of the debate about the ethics of forensic psychiatry. Nobody argues that psychiatrists serving forensic roles are not bound by psychiatric ethics. What Appelbaum and others have argued, correctly in my view, is that the ethical principles governing forensic psychiatry cannot be derived from the therapeutic ethic that governs that physician–patient relationship. The challenge is to formulate principles that are designed to govern this particular social role (and so, too, with other social roles) while being rooted in the professional aspirations of medicine, and while forbidding the sorts of abuses that arise when doctors surrender their professional identity and allow themselves to become agents of the state. Freedman and Halpern would serve the profession better by helping to frame the ethic of forensic psychiatry rather then by denying the need to undertake the task.

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2 Bonnie RJ. The death penalty: when doctors must say no. *BMJ* 1992; 305:381–383.

3 Bonnie RJ. Healing-killing conflicts: medical ethics and the death penalty. *Hastings Center Report* 1990; 20:12–16.

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More than any other specialty, psychiatry is enmeshed in conflict between the expectations of patients and society. The role of US psychiatry in the determination and restoration of competence for execution presents this conflict in particularly stark form.

The acrimony that characterises the international debate over this role reflects the larger failure of medical ethics discourse to address, in realistic fashion, the tension between physicians' obligations to their patients and their societies. To be sure, some criticism of this role stems from opposition to the death penalty. But the animating ideas behind most such criticism are the Hippocratic ethic of undivided loyalty to patients and the classic injunction, *primum non nocere*.

In practice, we routinely depart from these ideals, and traditional medical ethics offers us no guidance when we do so [1]. Society maintains contradictory private and public expectations of medicine [2]. As patients, we expect doctors to keep faith with us in moments of medical need, and we take offense when they fail to do so. Yet as citizens, we condition myriad rights, duties, and opportunities upon people's physical and mental health status, and we thereby ask of medicine that it serve multiple gatekeeping functions. Employment opportunities, eligibility for disability benefits [3], military service obligations [4], criminal responsibility, child custody, access to abortion [5], and ability to make contracts are among the matters that often hinge on medical evaluation and treatment.

Forensic psychiatrists earn their living by trying to meet these latter, public expectations, even when doing so results in harm to the people they attend. Their clinical work on death row, when competence for execution is at stake, poses this contradiction with singular poignancy. But this contradiction suffuses all of forensic practice – and all other exercises of clinical judgement for purposes other than patient care. Thus, the controversy over psychiatric involvement in capital punishment resonates far beyond death row. In this sense, Freedman and Halpern are on to something important in identifying a 'crisis' in the ethics of psychiatry.

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Is there a crisis in the ethics of US psychiatry? As managed care challenges physicians' traditional fidelity to patients' interests by encouraging them to place their own economic interests first, there may well be. But the notion of Freedman and Halpern that the crisis has been provoked by psychiatrists' evaluations of death row prisoners whose competence has been questioned would surely surprise most psychiatrists in the USA. Some background on the issue will reveal why.

Thirty-eight of the USA's 50 states allow the death penalty to be imposed, generally for homicides committed under aggravated circumstances. Under US constitutional law, however, prisoners cannot be executed if they are legally incompetent [1]. Generally that requirement has been interpreted to mean that prisoners who fail to understand the nature of the punishment and the reason for its imposition must be spared from execution. In one state (Maryland), such prisoners have their sentences commuted to life in prison and in another (Louisiana), if the state elects to treat the prisoner's incapacity, it can never carry out the death sentence. Although no centralised statistics are kept, evaluations of prisoners' competence to be executed appear to be quite uncommon.

What is it that troubles Freedman and Halpern? They believe that psychiatrists should not participate in evaluations of the competence of death row prisoners. Why they take that stance is not made terribly clear in their piece, other than the assertion that such evaluations constitute physician participation in execution – something that no one believes is ethically permissible. It is worth noting that their view is not supported by the official bodies charged with developing ethical standards for US medicine in general, and psychiatry in particular. The Council on Ethical and Judicial Affairs of the American Medical Association, after studying the issue for years, concluded that conducting such evaluations was not equivalent to participating in an execution. Indeed, '... without physician participation, [incompetent] individuals might be punished unjustifiably' [2]. This conclusion was supported by the American Medical Association's House of Delegates and Board. Similarly, the American Psychiatric Association's Committee on Ethics ruled that it was permissible for psychiatrists to engage in competence evaluations [3].

These conclusions are consonant with a reasoned view of the psychiatrist's role in competence evaluations. After assessing the prisoner's capacities, the psychiatrist testifies at a competence hearing regarding his or her conclusions. Other evidence is heard, as well, typically from prison guards and others who have been in contact with the prisoner. The determination regarding the prisoner's competence is left to the official decision maker, usually a judge. Taking part in this process is simply incommensurate with participation in execution.

Not only are such evaluations ethically permissible, but it is the very ban that Freedman and Halpern propose that would create impossible ethical dilemmas for psychiatrists. Envision a psychiatrist treating a prisoner on death row. The psychiatrist believes that the prisoner is psychotic or demented to the point where competence may be in question. As the prisoner is withdrawn and not overtly disruptive, no one else seems to notice. Under the rule proposed by Freedman and Halpern, the psychiatrist would have to stand by silently (because formally evaluating or testifying about a prisoner's competence would be forbidden) and watch the incompetent prisoner go to his death. How anybody could believe that such behavior is ethically justifiable is incomprehensible.

What, then, lies behind efforts to elevate an infrequently performed evaluation, agreed to be ethical by the professional groups that have studied it most closely, to the level of a 'crisis' in medical ethics? The death penalty evokes strong feelings among both its supporters and its opponents. Understandably, many opponents will seek any argument available to attempt to delegitimize the process. But it is manifestly unfair to psychiatrists and to death row prisoners themselves to use them as pawns in a game of political posturing over the use of the death penalty.

Although it is not clear from Freedman's and Halpern's piece, it should be noted that no one involved in this debate – not the American Medical Association, the American Psychiatric Association, nor me – argues that psychiatrists should treat persons found incompetent to be executed so that the sentence can be carried out. That is not at issue here. As for my views on the ethics of forensic psychiatry as a whole, which are misstated by Freedman and Halpern, I have addressed this issue at length elsewhere and refer the interested reader to that discussion [4].

References

1 Ford v Wainwright, 106 S.Ct.2595 (1986).

2 Council on Ethical and Judicial Affairs: *Report 6-A-95, Physician participation in capital punishment: evaluations of prisoner competence to be executed; treatment to restore competence to be executed.* American Medical Association; 1995.

to be executed, allowing intervention in the case of extreme suffering. Here I beg to differ that we should intervene in case of severe suffering from psychotic symptoms or self destructive behaviour, considering that the time between sentencing and actual execution could extend for years, and that court sentences can and are usually proceeded. However, I do agree with the guidelines of the Royal College of Psychiatrists (1992): 'On no account should the psychiatrist agree to state, after treatment, that the person is fit for execution'.

This commitment constitutes a component of the codes of ethics of several national and international medical organisations: the World Medical Association, World Psychiatric Association, American College of Physicians, British Medical Association, Royal College of Psychiatrists and the American Psychiatric Association.

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There are two peculiarities in the US legal system which may wrongly lead readers to think that the issue raised by Freedman and Halpern may not be of significant interest worldwide.

The first aspect is that the death penalty exists in some states in the USA and the problems are different where it does not. When a psychiatric patient commits an offence and is condemned to death, the insanity defence becomes a life saving issue. Where the death penalty does not exist it can be argued that long term sentences in jail or in a mental institution are equivalent; especially now that psychological rehabilitation is provided in many prisons whereas mental hospitals have deteriorated in many countries. It may even be better to have a limited prison sentence than to be an inmate of a mental institution without time limitation. Nevertheless, the institutional setting is essential for the job of professionals and an adequate doctor–patient relationship and treatment and rehabilitation procedures are difficult to carry out in prison.

The second peculiarity of the US legal system, and of Anglo-Saxon countries in general, is that the emphasis is placed on procedural law rather than the normative law. The latter is standard in other countries, especially those where Roman law prevails (France, Italy, Spain and Latin American countries). In normative law, the involvement of psychiatrists and other professionals as court experts seems to be easier and is carried out from a certain distance and with little involvement. The expert has two roles: the first is clinical diagnosis of the patient, the second is to evaluate the effects of the derangement of the patient's mind on the offence being judged.

Two recent cases in Spain help to clarify these points. In both there was an absence of mental disorders but psychiatrists were called to study the accused. In the first, one of a group of adolescents playing a game called 'role' brutally killed a sweeper in the early hours of the morning. The game involves the adoption of the role of different people during a normal day and this group adopted the role of 'vigilantes' or 'racial cleaners' liberating society from weak, old and foreign people. After a few failed attempts the group found the sweeper, aged, fat, and perhaps ugly looking, at night. During the trial there was a struggle between the psychologists and psychiatrists. The latter were unable to bring forward their argument as none of those involved in the crime, particularly the leader, fulfilled criteria for any psychiatric diagnosis. The psychologists, without the burden of having to provide a psychiatric diagnosis, were much more able to make a description of the personality of the accused and to suggest that they should be considered fully responsible. The psychiatrists, who were appointed by relatives of the accused, supported the notion that the accused were not responsible for their actions based on weak diagnostic formulations. In fact, they were trying an insanity defence without insanity being present. Here the pressures came not from the judicial system itself, but from one of the parties involved.

The other case, in which I participated along with another professor of psychiatry, involved a former head of the police forces in Spain who was accused of corruption and other similar offences. The image of this man in the press and the descriptions by his colleagues in the government as well as his own political party described him as being full of evil and as a psychopath or mentally abnormal person. The study of this person revealed no psychiatric disease and produced a detailed description of his personality and circumstances. The trial is ongoing, but the expert report was able to change the public perception of the accused. Removal of the stigma of mental illness also releases mental patients from the stigma of other social factors.

The lesson from Freedman's and Halpern's paper is that a psychiatrist should, in any circumstance, behave as a psychiatrist and only as a psychiatrist. A thorough reading of the Declaration of Madrid makes the task of psychiatrists more demanding even in circumstances not as extreme as those described by Freedman and Halpern.

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Navy threatened to quit GTMO over 'abuse'

By Pamela Hess
Pentagon correspondent

Washington, DC, Mar. 16 (UPI) -- The Navy's Criminal Investigative Service threatened to abandon the Guantanamo Bay jail interrogation operation because of the abuse of some detainees in late 2002 and helped force the Pentagon to undertake a review of the interrogation techniques approved by U.S. Defense Secretary Donald Rumsfeld, according to a classified Defense Department report.

The Navy's top lawyer warned the Pentagon's general counsel in December 2002 that some interrogation techniques used by intelligence personnel against prisoners held at the Cuban island jail were "unlawful and unworthy of the military services," according to the report, excerpts of which were read aloud by Sen. Carl Levin, D-Mich., at a Senate Armed Services Committee hearing Tuesday.

The account in the classified report prepared by Vice Adm. Albert Church differs from the Pentagon's explanation last year as to how the review of interrogation techniques came about.

According to a memo prepared by Navy General Counsel Alberto G. Mora for the Church investigation, the head of the Navy Criminal Investigation Service came to him in December 2002 with very serious concerns about the treatment of detainees. NCIS Director David Brant told Mora that one or more detainees were "being subjected to physical abuse and degrading treatment," Levin said, quoting from the Church report.

On advice of the DOD General Counsel William Haynes, Rumsfeld approved all but three of the new techniques, according to Pentagon documents and spokesman Larry DiRita at a meeting with reporters on May 20, 2004.

Memos leaked to the media and released under a Freedom of Information Act request detailed the request. It was broken into three categories. Category 1 included permission to yell at and deceive a detainee into thinking he is being interrogated by an official of another country with a reputation for harsh treatment of detainees.

Category 2 requested use of "stress positions" like standing for up to four hours and falsified documents and reports to deceive the detainee as well as solitary confinement for up to 30 days, with additional confinement possible if the commanding general approved it. It also requested sensory deprivation, hooding, removal of clothing, forced shaving and using detainee phobias like the fear of dogs to induce stress.

Category 3 requested permission to use scenarios that would convince the detainee that death or severely painful consequences are imminent for him and his family, exposure to cold weather or water (with medical monitoring), and the use of a wet towel and dripping water to induce the misperception of suffocation. It also requested permission to use "mild, non-injurious physical contact such as grabbing, poking in the chest with a finger and light pushing."

On Dec. 2, Rumsfeld approved all of category 1 and 2, and only the mild-non-injurious contact request in category 3. Between Dec. 2 and January 15, many of those techniques were used.

A defense official told UPI Wednesday it is unlikely DiRita or most people working the interrogation issue in the office of the Secretary of Defense were even aware of the NCIS or Navy general counsel's objections until the Church report was released. They were only made known to the DOD general counsel in December or January, which convinced Haynes to advise Rumsfeld to rescind the interrogation policy while the working group was convened.

The NCIS was, apparently, mollified by the working group process and ultimate policy issued on April 16.

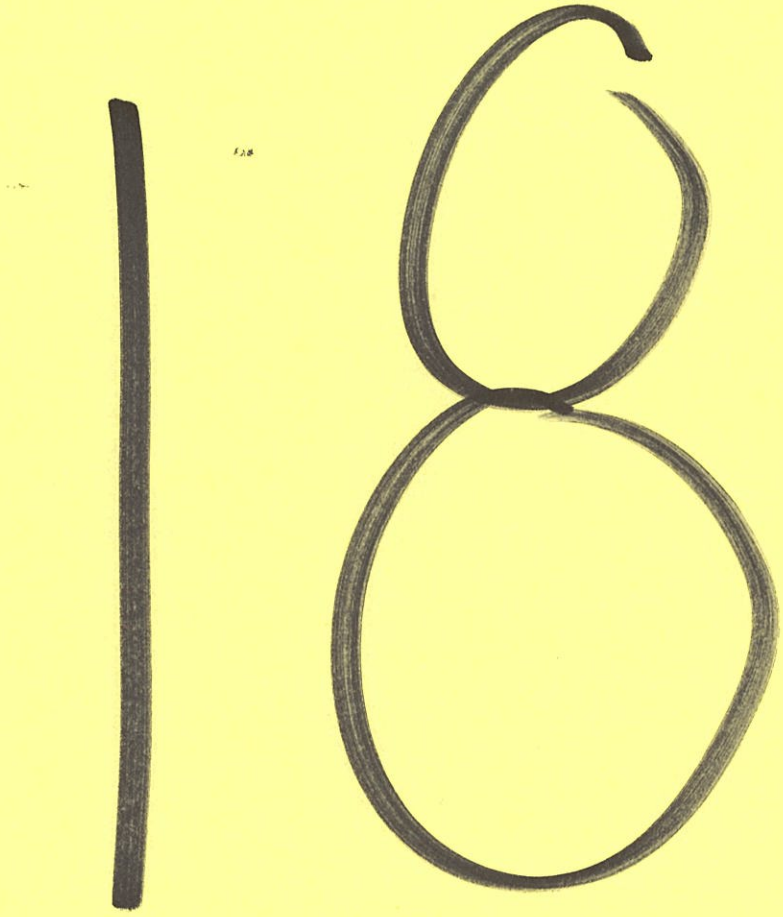
"They didn't leave. They've been there doing their thing," the defense official said.

The working group deliberations were not without conflict, and defense officials acknowledge that not everyone is satisfied with the outcome.

During the subsequent three-month long deliberation of the working group on detainee interrogation, the military service lawyers known as judge advocates general voiced objections to the White House decision that the prisoners captured in the Afghan war be exempt from Geneva Convention protections. They were overruled by the DOD general counsel.

The working group produced a list of 35 suggested interrogation techniques. Rumsfeld accepted 24 of them, 17 of which were already part of standard Army doctrine. Nearly all the category 2 and 3 techniques were dropped.

Rumsfeld accepted the addition of the "Mutt and Jeff" technique, which had been in the Army's field manual for interrogation in 1987. It is more commonly known as the good cop-bad cop technique.



ICRC International Committee of the Red Cross

5-11-2004 Operational update

US detention related to the events of 11 September 2001 and its aftermath - the role of the ICRC

The article explains the purpose of the ICRC visits and its procedures, and outlines its concerns, including the fate of people held at undisclosed locations.

The terrible events of 11 September 2001 shocked the world including the ICRC, which immediately condemned the attacks on the United States *(see Press release, 11 September 2001)*.

The ICRC recognises the significant challenge the United States and other countries face in defending their citizens against terrorist attacks. Nevertheless, there are serious divergences of opinion about the relevant laws which apply to the US government's response to terrorism. The ICRC is especially concerned about the fact that the US detains an unknown number of people outside any legal framework.

Many of those captured in the context of the so-called War on Terror are being held at US detention facilities in Bagram and Kandahar in Afghanistan and in Guantanamo Bay, Cuba. A small number of persons are furthermore detained in Charleston, USA. According to public statements by official US sources, a number of detainees are also being held incommunicado at undisclosed locations.

The ICRC has been visiting detainees in Bagram and Kandahar, Guantanamo Bay, and in Charleston. The ICRC has also repeatedly appealed to the American authorities for access to people detained in undisclosed locations.

ICRC in Bagram, Afghanistan

The ICRC has been visiting detainees at the US-run Bagram military airbase since January 2002. Most of them are Afghans captured by the US-led coalition in Southern and Eastern Afghanistan. As of October 2004, around 300 detainees were being held at Bagram. Since the beginning of 2004, just over 1,400 Red Cross Messages have been exchanged between detainees and their families.

ICRC in Kandahar, Afghanistan

The ICRC visited the US detention facility in Kandahar from December 2001 when it opened until its closure in June 2002. The institution requested renewed access to the facility in early June, when it resumed its functions. The first ICRC visit to Kandahar detention facility took place in late June 2004. Visits are being made on a regular basis to around 250 detainees. To date some 150 Red Cross Messages have been exchanged between detainees and their families.

ICRC in Guantanamo Bay, Cuba

The ICRC has been visiting detainees held at Guantanamo Bay, Cuba since January 2002. There are currently about 550 detainees from roughly 40 countries speaking about 17 different languages. As of October 2004, the ICRC had facilitated the exchange of nearly 10,000 Red Cross messages between the detainees and their families.

The ICRC regularly discusses its findings concerning Bagram, Kandahar and Guantanamo Bay with the military authorities in the camps as well as with the appropriate US representatives in Kabul and Washington. While the ICRC has felt compelled to make some of its concerns public, notably regarding the legal status of the detainees, the primary channel for addressing issues related to detention remains its direct and confidential dialogue with the US authorities.

Confidentiality. Why?

Wherever the ICRC visits places of detention, its findings and observations about the conditions of detention and the treatment of detainees are discussed directly and confidentially with the authorities in charge. Bagram, Kandahar and Guantanamo Bay are no exceptions. The ICRC's lack of public comment on the conditions of detention and the treatment of detainees must therefore not be interpreted to mean that it has no concerns.

Confidentiality is an important working tool for the ICRC in order to preserve the exclusively humanitarian and neutral nature of its work. The purpose of this policy is to ensure that the ICRC obtains and, importantly, maintains, access to tens of thousands of detainees around the world held in highly sensitive situations of armed conflict or other situations of violence.

The ICRC is also concerned that any information it divulges about its findings could easily be exploited for political gain.

Red Cross messages

For most detainees in Bagram, Kandahar and Guantanamo Bay and their families, Red Cross messages are the only means of maintaining regular contact. As the feeling of isolation and uncertainty about their future has increased among the detainees, particularly in Bagram and Guantanamo Bay, these messages have become more and more valuable for them and their families. Red Cross messages are strictly intended for the exchange of personal and family news and are routinely censored by the US authorities. This corresponds to standard worldwide practice wherever the ICRC visits places of detention.

The Red Cross message service for detainees and their families is a major logistical exercise, involving a number of ICRC delegations worldwide, as well as national Red Cross and Red Crescent societies in the detainees' home countries. Every message is delivered by hand to the detainees and their families. The logistics involved and the censorship of the messages by authorities can unfortunately slow down the process.

Juveniles at Guantanamo Bay

The ICRC believes that the US continues to detain two juveniles i.e. detainees under 18 years of age at Guantanamo Bay. International law recognises that juveniles in detention have special needs and must therefore be treated differently from adults.

Military Commissions for Guantanamo Bay detainees

The US has publicly announced its plans to set up military commissions to try at least some of the detainees at Guantanamo Bay.

International Humanitarian Law provides for the prosecution of people suspected of having committed war crimes or any other criminal offence. It requires that the individuals concerned be afforded essential judicial guarantees. These include the presumption of innocence, the right to be tried by an impartial and independent tribunal, the right to qualified legal counsel and the exclusion of any evidence obtained as a result of torture or other cruel, inhuman or degrading treatment.

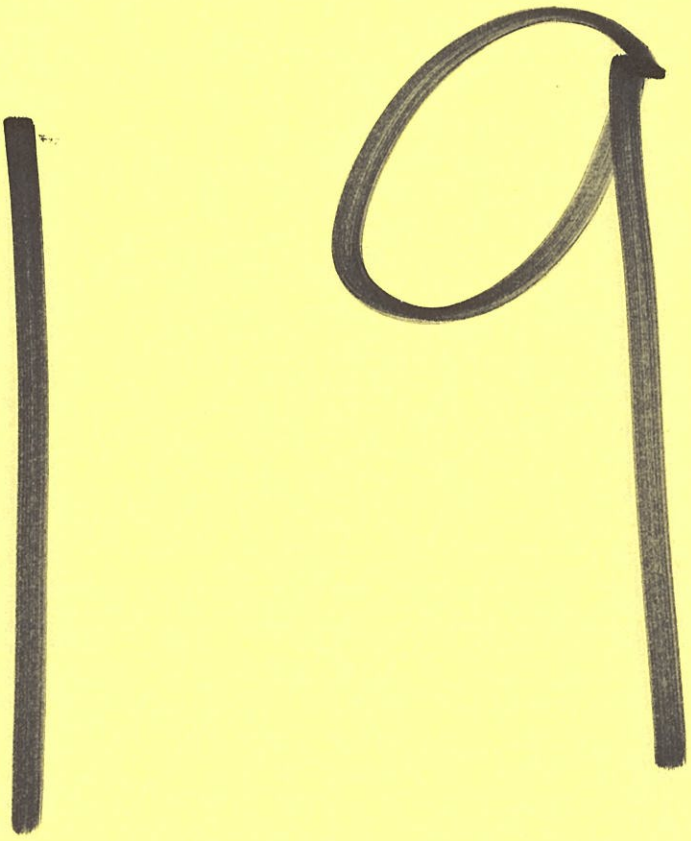
liberty. However, since the detainees, particularly in Guantanamo Bay, have been subjected to unusually long periods of interrogation, the ICRC closely monitors the impact this has on them. Any interrogation has to be conducted in accordance with basic humanitarian standards.

Beyond Bagram, Kandahar and Guantanamo Bay, the ICRC is increasingly concerned about the fate of an unknown number of people captured as part of the so-called global war on terror and held in undisclosed locations. For the ICRC, obtaining information on these detainees and access to them is an important humanitarian priority and a logical continuation of its current detention work in Afghanistan and Guantanamo Bay. Dialogue continues with the US authorities to resolve this issue.

To find out more about the ICRC's detention work in Iraq see operational update *of 31 May 2004*

5-11-2004

Section: The ICRC worldwide > The Americas > United States



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In Service of Two Masters: The Ethical–Legal Dilemma Faced by Military Psychologists

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Military clinical psychologists may find themselves caught between apparently contradictory requirements of the Department of Defense (DOD) and the American Psychological Association (APA). Two cases involving confidentiality are presented for illustration: Case 1—an active-duty Army officer was referred for psychological consultation after expressing suicidal ideation at the work site; Case 2—a self-referred long-term psychotherapy patient reported having been sexually assaulted by a DOD physician. This article discusses and analyzes these cases, raises issues and dilemmas presented by the demands of DOD and APA, and presents recommendations.

Confidentiality of communication between patients and Department of Defense (DOD) health care providers is protected by agency directives (e.g., DOD, 1975) and Army, Navy, and Air Force regulations (e.g., Department of the Army [DA], 1987). Although federal statutes, DOD directives, and service regulations are written so as to respect the privacy of individuals, they also mandate access to confidential material by federal employees with a "need for the record in the performance of their duties" (DA, 1982, 1985a; DOD, 1975). Consumer consent is not required for such a release.

Military psychologists must follow DOD directives while adhering to the standards, principles, and guidelines of the American Psychological Association (APA). Often these psychologists have little opportunity to influence the rules and regulations of the DOD. As a consequence, practices regarding patient confidentiality that are acceptable as defined by military regulations sometimes conflict with standards of the APA. This article presents two such cases (with disguised identifying information) in an attempt to sensitize military clinical–counseling psychologists to areas of conflict so as to minimize any untoward effects and enhance the management of similar cases in the future.

Case 1

The patient, a 32-year-old Army officer, was referred on an "emergency" basis by the patient's supervisor for a psychological evaluation. The supervisor expressed concern regarding the officer's potential for suicide. Earlier in the day the officer in question had expressed vague suicidal ideation to a peer at the work site. This statement had been interpreted as a reflection of feelings of despondency and was reported to the section supervisor.

The patient refused to complete the clinic's intake paperwork and requested that the psychologist not maintain a clinical case file (patient record) because of concerns regarding the potentially adverse impact of a psychological evaluation on one's military career. The psychologist explained that service regulations mandated documentation of the content of the evaluation but failed to document this advisement in the patient's clinical case file. After determining that the patient was not an immediate danger to self and could be helped by counseling, the patient was given the option of seeing a civilian psychologist as an alternative offering greater confidentiality. The patient declined because of financial concerns and entered into a therapeutic relationship with the military psychologist. The patient was seen for eight 1-hr sessions of short-term, crisis-oriented therapy, after which the psychologist was transferred to an overseas duty assignment. The case was discussed with the psychologist's supervisor to ensure understanding of the essential issues and to coordinate follow-up treatment.

After the psychologist's transfer, the patient's supervisor sent a written request to the clinic asking for information on the evaluation and consultation. The supervisor specifically wanted to know whether the officer should be permitted to

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viewed the psychologist as having failed to properly manage the dual demands of APA and DOD. Military psychologists will be well served to remember this.

This case demonstrates the importance of patient advisement of limits of confidentiality and careful documentation of such in patient charts. In a referral situation such as is described in this case, it is highly probable that a supervisor will exercise "need to know" rights and ask for a psychological report. In such referral situations it is especially important for psychologists to have patients routinely sign release of information statements and informed-consent documents that specifically outline limits of confidentiality that apply to the setting.

Case 2

The patient, a 32-year-old spouse of a career soldier, had been followed in individual and group therapy by psychologists in the hospital for several years. The patient had a long history of psychological difficulties, with several brief hospitalizations, and had been diagnosed with borderline personality disorder. Polydrug abuse and multiple sexual involvements had been longstanding problems. As a result of 3 years of continuing therapy at the hospital, the quality of the patient's work and interpersonal relationships had improved. One day, the patient reported to the clinic in an agitated state and claimed to have been sexually assaulted by a physician during a treatment procedure. The patient stated that the incident had occurred in a private examination room. The patient expressed feelings of anger and confusion, an inability to relax or sleep, and described abuse of drugs (chlordiazepoxide [Librium] and alcohol) to deal with the emotional distress. The patient was tearful, verbalized feelings of embarrassment and humiliation, avoided eye contact, exhibited hypervigilance and increased irritability, and expressed suicidal ideation. Crisis intervention was initiated, and a no-suicide contract was negotiated. The patient did not want to file charges against the accused physician and insisted that the psychologist maintain confidentiality.

Several weeks later, the patient arrived at a psychotherapy appointment with droopy eyes, slurred speech, and a wavering gait, and expressed severe self-deprecatory thoughts. In the psychologist's opinion, the patient had become a danger to self because of expressed suicidal ideation and admission to having ingested an excess of alcohol and Librium. The patient was asked to remain in the clinic for several hours to monitor respiration and alertness. The patient was then released (with permission) to the custody of the spouse, who agreed to remain with the patient until a follow-up appointment the next day. (In retrospect, it may have been more appropriate to insist that the patient undergo an emergency drug screen for toxicity to ensure physical safety.)

The case was presented to the departmental Quality Assurance (QA) Committee as an issue of "adverse reaction to psychotropic drugs—overmedication." The patient had received in excess of 250 tablets of Librium by prescription from the alleged assailant in a span of less than 3 weeks. This breach of confidentiality was discussed with the patient as a duty to protect from a future untoward effect caused by medication–alcohol interaction and as a quality assurance mandatory reporting requirement. When learning of this QA issue, the hospital commander initiated an official investigation. The appointed investigating officer confiscated the patient's psychological clinical case file without consulting the psychologist health care provider. This occurred when the investigating officer, a senior member of the medical staff, entered the clinic during other than normal duty hours and directed the duty clerk to release the record. The contents of the record were immediately brought to the attention of command and many others with a "need to know" (e.g., military lawyers and administrative staff).

The investigating officer interviewed the patient, who was quite distressed and ultimately revealed all that had happened sexually with the alleged assailant. When confronted with the charges by the investigating officer, the assailant admitted to all allegations.

The patient expressed concern that confidentiality had been breached and that his or her personal history had become part of an investigative record. The patient retained a lawyer and threatened the psychologist with legal action or an ethics complaint filed with the APA or both.

The hospital commander saw the psychologist's actions as misguided by APA principles and guidelines. The commander felt that the psychologist had conspired with the patient in failing to report a serious crime. Concealing a crime could, in itself, be interpreted as a violation of military law. The commander believed that reporting the alleged criminal action was more important than protecting patient confidentiality.

Discussion

The Ethical Principles of Psychologists direct that every effort be "made to avoid undue invasion of privacy" (APA, 1990a, p. 393) and that psychologists "have a primary obligation to respect the confidentiality of information obtained" from patients (APA, 1990b, p. 392). According to the Speciality Guidelines for the Delivery of Services, providers are to be "continually sensitive to the issue of confidentiality of information" (APA, 1981, p. 646). To have revealed the alleged sexual abuse without the express written consent of the patient would have violated these principles. While presenting the alleged sexual abuse, the patient insisted that the psychologist maintain confidentiality because the patient did not want to suffer additional hurt and embarrassment by going public with information about the assault. The psychologist attempted to obtain permission from the patient to breach confidentiality, but the patient refused to grant it; the psychologist was thereby duty bound to respect the patient's confidentiality. Siegel (1976) has provided support for this position, as have other senior psychologists (Pope & Bajt, 1988). Research on psychological treatment (advocacy) for victims of rape also provides support for such action (Burgess & Holmstrom, 1979).

When the patient presented to the clinic in a toxic state, the psychologist was required to report this to the QA committee in accordance with hospital policy. This required execution of a breach of confidentiality by informing the QA Committee of a risk management problem (adverse reaction to psychotropic drugs—overmedication). Hospital QA peer review and related activities are recognized and accepted processes for reviewing the efficacy of clinical practices. Although they purport to respect patient confidentiality, such may not be the case (Siegler,

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20

The Politics of Pain

Torturers and Their Masters

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4 goes on to ask each state to declare all acts of torture offenses under its criminal law.

But despite the fact that torture is a crime under the U.N. Convention and other relevant international frameworks, and is similarly defined in the national legal codes of many of the U.N.'s member states, it is a practice that is widespread throughout the world. If anything, the incidence of torture appears to be on the rise. An Amnesty International document issued in 1991 reported the use of torture in 96 states—including, no doubt, many states that have ratified the U.N. Convention and whose own national legal codes may even include provisions against torture. A U.S. State Department report for the same year suggested that 60 countries practiced torture systematically, as a matter of policy; sporadic torture was registered in 28 countries and allegations of torture occurred in an additional 9 countries.[3]

Torture as a Crime of Obedience

Some of the instances of torture that occur in one or another state constitute "ordinary" crimes—that is, crimes committed in violation of the expectations and instructions of authority. Torture would be an ordinary crime in this sense if it were carried out by individual officials at their own initiative and in disregard of the policies and orders under which they function. Similarly, officials could be charged with torture as an ordinary crime if they used means of pressure in excess of what was legally permitted. For example, the report of the Landau Commission, appointed by the Israeli government to investigate the practices of the General Security Service, concluded that a certain amount of pressure was permissible in security-related interrogations, that "the means of pressure should principally take the form of non-violent psychological pressure," but that "the exertion of a moderate measure of physical pressure" may be necessary when the psychological techniques "do not attain their purpose."[4] The Landau Report goes on to propose strict guidelines for permissible pressure. The line between "moderate physical pressure" and torture (and indeed between permissible and excessive psychological pressure) is hard to draw and the attempt to make such distinctions invites abuse. Still, insofar as there are guidelines, there is a basis for accusing officials of committing torture as an ordinary crime when they act in violation of these guidelines. Indeed, there have been some cases—including cases in Israel—in which officials have been tried and convicted for acts of torture that they committed at their own initiative or in excess of legally permitted limits. Trials of individuals for engaging in torture in their official positions are rare and punishments

responsibility by reference to superior orders, claiming that they are just cogs in the machine who are not in a position to set policy and are simply doing what they are told to do. Superiors are often able to deny responsibility because they are various steps removed from the actual acts of torture themselves. They may claim that the initiative was taken at a lower level of the hierarchy, that they had no idea that torture was taking place, that they did not order or condone torture, that their instructions were misunderstood or misinterpreted or inaccurately communicated across the hierarchy. Higher-level superiors may in fact not have issued specific orders to engage in torture, but they are the ones who formulate the policies, create the atmosphere, and establish the framework within which officials at intermediate levels of the hierarchy translate general policy directives into specific acts of torture. It has proven particularly difficult, however, to establish causal links between the general atmosphere and policy directives conveyed by the top leadership and the practices designed and carried out at lower levels of the hierarchy.

The denials of responsibility for crimes of obedience by both superiors (on the grounds that they were not the ones who committed the action) and subordinates (on the grounds that they were not the ones who decided on the action) often cancel each other, with the unfortunate result that no one is held responsible: Responsibility for such actions tends to be entirely lost. The question, however, is not "who is responsible?"—the actor or the authority—but "who is responsible for *what*?" When the question is framed that way, it becomes clear that both ought to be held responsible. The actors—the torturers themselves—are properly held responsible for the actions they perform and the harm they cause, even if they are acting under superior orders. Since the adoption of the Nuremberg Principles after World War II which have been incorporated into the military codes of all Western states, superior orders cannot be used as an absolute defense for criminal actions on the part of subordinates. The U.N. Convention against Torture specifically applies this principle to torturers in the clause, cited above, that "an order from a superior officer or a public authority may not be invoked as a justification of torture." Subordinates have the obligation to evaluate the legality of orders and to disobey those orders that they know or should have known to be illegal.

Superiors, for their part, have the obligation to consider the consequences of the policies they set and to oversee the ways in which those policies are translated into specific orders and actions as they move down the ladder. The authorities' obligation of oversight makes the defense of ignorance of or lack of control over the actions of subordinates generally unacceptable since they are expected to know and to control

In making this observation, I am not endorsing the view that *anyone* could become a torturer. Some cite the well-known obedience experiments by Stanley Milgram[8] as evidence that any ordinary person could be brought into a psychologist's laboratory and, under the appropriate circumstances, converted into a torturer and potential killer. Subjects in this research were led to believe that they were participating in a learning experiment and asked to deliver electric shocks to another subject whenever he made an error in a word association task. In fact this other "subject" was an actor working with the experimenter and was not connected to the shock apparatus. The experimenter instructed the subjects to continue delivering shocks to the "learner" even after he began to cry out in pain, demanded to be released, and eventually stopped responding altogether, and to increase the level of the shock beyond a point that subjects were led to believe was severe and dangerous. Milgram found, in his standard experimental condition, that some 65% of the subjects went all the way in obeying the experimenter's instructions, although many of them displayed great distress as they carried out the task. This level of obedience is disturbingly high and I take these findings very seriously; I use them extensively in my teaching and writing. They suggest that a situation can be structured so powerfully that ordinary people can be induced to engage in acts that inflict severe pain and suffering on another and may cause him injury and conceivably even death, simply because an experiment in which they agreed to participate ostensibly requires them to do so. Yet, the obedience experiments do not provide evidence that *anyone* could be turned into a torturer. Those who cite them to that effect forget that some 35% of the subjects—a sizable minority—refused to obey the experimenter's instructions.

Thus, Milgram's findings are consistent with the view that individuals differ in their propensity to engage in torture. I assume that not everyone can be turned into a torturer, and certainly that not everyone can be induced to become a torturer with the same degree of ease and to engage in torture with the same degree of enthusiasm. But it does seem clear that one does not have to be a sadist, or a psychopath, or a paranoid psychotic in order to become a torturer. Moreover, the individual differences that account for readiness to engage in torture are probably related as much to people's orientation toward authority[9] as they are to their propensity toward aggression or their sense of compassion.

Turning to cultural differences, once again I feel certain that they play an important role, particularly if we focus on *political* culture. Thus, Berto Jongman[10] shows that human rights violations, including torture, are much more likely to occur in non-democratic societies than they are in democratic societies: In 1990, torture was reported in 84% of countries

level, the central question is: What are the structural and situational conditions that make torture *necessary* as an instrument of policy in the eyes of the relevant authorities? At the micro-level, the question is: What are the conditions that make torture *possible* for those individuals and organizations who are asked to implement this policy?

The Use of Torture as an Instrument of Policy

The emergence or reemergence of torture as an instrument of policy in the twentieth century is directly related to the nature of the modern state. In particular, as Edward Peters[14] argues in his historical study, torture arises from the combination of two features of the modern state: its vast power and its enormous vulnerability to state enemies, internal and external. The power of the modern state rests in the extent to which it affects all aspects of the lives of its citizens and the resources that it can mobilize to control its population. The vulnerability of the modern state stems from the high degree of interdependence of the political, economic, and social institutions required to run a modern society and the resulting ease with which social order can disintegrate and the political authorities can lose control when their legitimacy declines in the eyes of their population or when they confront terrorism and insurgency. Torture becomes state policy when the authorities perceive an active threat to the security of the state from internal or external sources and decide to use the vast power at their disposal to counter that threat by repressive means.

The recourse to repression is likely to occur in situations in which opposition—any opposition or opposition from a particular quarter—represents a challenge to the *legitimacy* of those in power and thus a fundamental threat to their continued ability to maintain power. This may be the case in states in which the legitimacy of the rulers rests on the basis of a unitary, unchallengeable ideology, political or religious, such as Communism in China and not so long ago in the Soviet Union and its East European allies, or Islam in Iran. It may also be the case in states that are run by a ruling clique with an extremely narrow population base—in socioeconomic and/or ethnic terms—but with the support of the military forces, such as Iraq and Syria, or El Salvador and other Latin American states at various times. Torture may also be used, sporadically or even systematically, by democratic regimes (as mentioned above) that find themselves in charge of ethnically distinct populations or subpopulations that do not accept their rule, such as Israel in the occupied territories or Britain in Northern Ireland.

state claims to embody, the rule of God, the survival of Western civilization, or the integrity of national institutions.

Second, the *agents* of torture are defined as a professional force with a significant role in protecting the state against internal threats to its security. The power of the state allows it to mobilize the necessary resources to establish a torture apparatus. A central component of that mobilization process is the recruitment of a cadre of torture practitioners through the development of what is in effect an organized profession—a profession that is wholly owned by the state, that operates within the state's internal security framework, and that is dedicated to the service and protection of the state.

Third, the *targets* of torture are defined as enemies of the state who constitute serious threats to the state's security and survival. For that, as well as for other reasons, such as their ethnicity or ideology, they are placed outside the protection of the state. In the modern state, individual rights in effect derive from the state. Thus, to be excluded from the state—to be denied the rights of citizenship—is tantamount to becoming a non-person vulnerable to arbitrary treatment, to torture, and ultimately to extermination.

Social Processes Facilitating Participation in Torture

The three points at which the security concerns and power of the state contribute to a policy of torture at the *macro-level*—i.e., the justification for torture, the agents of torture, and the targets of the torture—can be linked to three social processes that facilitate participation in torture at the *micro-level*: the processes of authorization, routinization, and dehumanization, which I distinguished in my earlier analysis of sanctioned massacres and other crimes of obedience.[18] The justification of torture as a means of protecting the state against threats to its security helps to *authorize* the practice; the development of a profession of torturers as part of the state's security apparatus helps to *routinize* the administration of torture; and the designation of the targets of torture as enemies of the state who are excluded from the state's protection helps to *dehumanize* the victims.

In my earlier analysis of sanctioned massacres, I have argued that, to understand participation in massacre, it is less important to explore the forces that push people into performing such violent acts than to explore those forces that contribute to the weakening of moral restraints against performing acts that people would normally find unacceptable. Within this framework, I proposed that *authorization* helps to define the situation in such a way that standard moral principles do not apply. The individual is not acting as an independent moral agent and therefore feels

physicians in legitimizing torture and the systematic killing of "undesirables" and enemies of the state is the case of the Nazi doctors who helped to formulate the biomedical vision underlying the Nazi genocidal programs.[21]

Another source of legitimization of torture is the legal context in which it often takes place. One of the common uses of torture is as an adjunct to judicial proceedings, where it is designed to obtain evidence to be introduced into trials. This practice goes back to the early uses of torture, in the Roman period and in the Middle Ages, as a central part of the process of producing a confession, which was deemed necessary to establish the guilt of the accused.[22] More generally, the justification of torture as a necessary means of ferreting out "the truth" helps to surround it with an aura of legitimacy.

Routinization

One important indicator and contributing factor to the routinization of torture is the establishment of torturers as a professional group. Professionalizing the practice of torture clearly contributes to normalizing their work; it also contributes to ennobling their efforts since it conveys the image of torture as a special profession dedicated to the service of the state. Like other professionals, torturers undergo professional training to prepare them for their roles.[23] Although some torturers may seek out this occupation because of their sadistic inclinations, many are ordinary people who come to this work via a number of different routes. They become "professional torturers," however, by going through a rigorous process of training, socialization, and indoctrination. Typically, this process includes torture resistance training, which acclimatizes them to cruelty.[24]

Another element of the professionalization of torture is that it has become an international enterprise. Torturers from different parts of the world come together in international meetings in which they share information about training procedures and torture techniques. The similarity in the techniques of torture used across the world is startling. Some of this is probably due to independent discovery and invention, but much of it can be credited to professional exchange.

The torture process itself also shows signs of considerable routinization. The process usually involves a series of steps, clearly identified, and following each other in regular sequence. The different torture techniques, as well as the different torture chambers, are typically designated by special names, often with a euphemistic or ironic quality. These names are not so much designed to hide the reality of what is

they are guilty never arises. The whole torture apparatus operates on the assumption that those who are brought in for torture are guerrillas, insurgents, or terrorists who have committed and/or were about to commit dangerous crimes against the state. Thus, torture is designed only to punish the guilty, to warn their accomplices, and most importantly to elicit the truth from them. Indeed, torture is often justified on the grounds that it is the only way to elicit information necessary for the protection of the state and its citizens, such as information about the identity and whereabouts of terrorist leaders or about planned terrorist operations that the torture victims are presumed to have in their possession.

A contributing factor to the dehumanization of torture victims is the fact that they are often outside the ethnic or religious community of the torturers and of the dominant sector of the society, as has been the case, among many others, for Kurds in Iraq, for Bahais in Iran, for Palestinians in Kuwait and in the Israeli-occupied territories, for Irish Catholics in Northern Ireland, or for Bosnian Muslims in the former Yugoslavia. In many cases, the victims' ethnic or religious identity is itself the primary reason for their vulnerability to torture. In other cases, ethnic or religious identity is a factor in dissent or insurgency. In all cases, it facilitates exclusion and dehumanization, thus removing one of the constraints against torture and other serious violations of human rights.

Conclusion

The present analysis suggests several conditions under which torture becomes an instrument of state policy and the authority structure of the state is fully utilized to implement that policy. First, there is the perception by state authorities that the security of the state is under severe threat. At the macro-level, such a perception can justify torture while, at the micro-level, it may contribute to its authorization. Second, there is the existence of an elaborate and powerful apparatus charged with protecting the security of the state. At the macro-level, this may lead to the recruitment and training of professional torturers as part of that apparatus. At the micro-level, it can contribute to the routinization of torture. Finally, there is the existence of disaffected ethnic, religious, political, or other groups within or under the control of the state that do not enjoy full citizenship rights. At the macro-level, this may lead to their designation as enemies of the state and, consequently, as appropriate targets for torture. At the micro-level, this can result in their dehumanization. These conditions and hence the propensity for torture are endemic to the autocratic security state. Part of the answer to torture

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13. cf. H. Radtke, "Torture as an Illegal Means of Control." In F. Bockle and J. Pohier (Eds.), *The Death Penalty and Torture*. New York: Seabury Press, 1979, pp. 3-15.

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17. See Heinz, this volume.

18. H. C. Kelman, "Violence Without Moral Restraints: Reflections on the Dehumanization of Victims and Victimizers." *Journal of Social Issues*, 1973, 29(4), pp. 25-61; Kelman and Hamilton, *Crimes of Obedience*.

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23. Radtke, "Torture as an Illegal Means of Control"; Gibson, "Factors Contributing to the Creation of a Torturer."

24. Radtke, "Torture as an Illegal Means of Control"; see also Crelinsten, this volume.

25. Radtke, "Torture as an Illegal Means of Control."

26. Peters, *Torture*.

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American Medical Association
Physicians dedicated to the health of America

Medicine and Society

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Physicians' Obligation to Speak Out for Prisoners' Health

by Daryl Matthews, MD

As this is written, military review hearings at the US detention center at Guantánamo Bay, Cuba, are under way to determine whether any of the individual detainees has been wrongly classified as an "illegal combatant" by the Department of Defense, and is, thus, eligible for repatriation. The men facing these hearings have been held, often in solitary confinement, for up to 2½ years and have not had access to legal counsel. It appears from news reports that a majority of detainees are refusing to participate in the hearings.

On the face of it, this would seem altogether irrational. Some detainees may be released as a result of the military review hearings, so there would appear to be no downside to participating. Only a few detainees currently face charges that will result in their being tried before military commissions, so those refusing the military review hearing process may still be held indefinitely without trial. And these review hearings are not the habeas corpus proceedings mandated by the US Supreme

geographic boundaries, and political divides" [4].

The declaration calls upon us to "respect the dignity of every individual" and to "refrain from supporting or committing crimes against humanity and condemn all such acts." We are also asked to "advocate for . . . political changes that ameliorate suffering and contribute to human well-being" [4].

The global political changes that might be made in service of these goals are limitless and many would be difficult or impossible to achieve. However, in the area of US treatment of alleged "illegal combatants," change may be possible. The Department of Defense has yielded to political pressure in many ways as it has gradually altered the military commission rules, released groups of detainees from particular nations, introduced a review hearings procedure, and opened Guantánamo itself to journalistic scrutiny.

Medical and mental health professionals are in a unique position to advocate for humane conditions of detention, fair legal processes, adequate psychiatric care, and appropriate psycho-legal evaluations. The Guantánamo detainees, exposed to a host of potential mental health risks, are hidden from professional and public scrutiny to an extent unparalleled by a correctional population in recent US history. Professional societies have avoided the controversies posed by the Guantánamo detentions; only human rights organizations have come forward to express concern about the detainees' mental health: The International Committee of the Red Cross, Amnesty International, Human Rights Watch, and Physicians for Human Rights, to name a few. Perhaps our professions are so silent because we have become accustomed to maintaining silence about the massive human rights violations so prevalent in US jails and prisons (5). However, public examination and discussion of the Guantánamo situation may also help us take a clearer look at our responsibilities at home.

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Abu Ghraib: its legacy for military medicine

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The complicity of US military medical personnel during abuses of detainees in Iraq, Afghanistan, and Guantanamo Bay is of great importance to human rights, medical ethics, and military medicine. Government documents show that the US military medical system failed to protect detainees' human rights, sometimes collaborated with interrogators or abusive guards, and failed to properly report injuries or deaths caused by beatings.[1–23] An inquiry into the behaviour of medical personnel in places such as Abu Ghraib could lead to valuable reforms within military medicine.

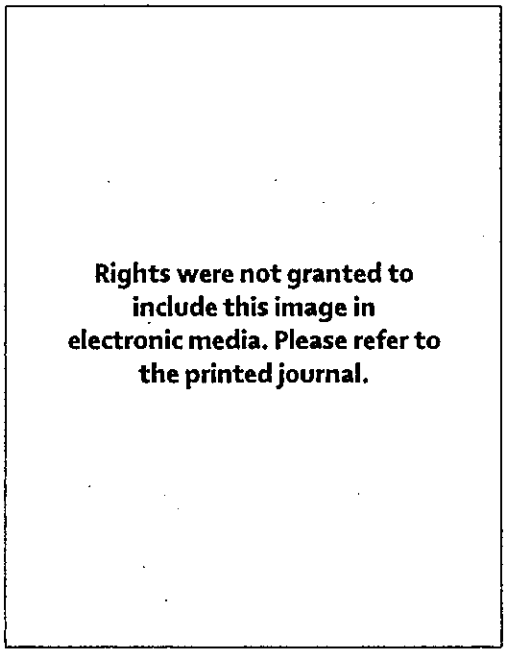
The policies

As the Bush administration planned to retaliate against al-Qaeda's terrorist attacks on the USA, it was reluctant to accept that the Geneva Convention Relative to the Treatment of Prisoners of War would apply to al-Qaeda detainees.[24] In January, 2002, a memorandum from the US Department of Justice to the Department of Defense concluded that since al-Qaeda was not a national signatory to international conventions and treaties, these obligations did not apply.[4] It also concluded that the Convention did not apply to Taliban detainees because al-Qaeda's influence over Afghanistan's government meant that it could not be a party to treaties. In February, 2002, the US president signed an executive order stating that although the Geneva Conventions did not apply to al-Qaeda or Taliban detainees, "our nation . . . will continue to be a strong supporter of Geneva and its principles . . . the United States Armed Forces shall continue to treat detainees humanely and, to the extent appropriate and consistent with military necessity in a manner consistent with the principles of Geneva."[5] This phrasing subordinates US compliance to the Geneva Convention to undefined "military necessity."

An August, 2002 Justice Department memorandum to the President and a March, 2003 Defense Department Working Group distinguished cruel, inhumane, or degrading treatment, which could be permitted in US military detention centres, from torture, which was ordinarily banned except when the President set aside the US commitment to the Convention in exercising his discretionary war-making powers.[17] These memoranda semantically analysed the words "harm" or "profound disruption of the personality" in legal definitions of torture without grounding the terms on references to research showing the prevalence, severity, or duration of harm from abusing detainees.[25–30] Also, the memoranda do not distinguish between coercive interrogation involving soldiers from those employing medical personnel or expertise. For example, both documents excuse the use of drugs during interrogation.[17] Neither document mentions medical ethics codes or the history of medical or psychiatric complicity with torture or inhumane treatment.[25,26,31,32]

In late 2002, the Secretary of Defense approved "Counter Resistance Techniques" including nudity, isolation, and exploiting fear of dogs for interrogating al-Qaeda suspects at Guantanamo.[6] In April, he revised those techniques and advised those devising interrogation plans to give consideration to the view of other countries that some of the authorised techniques such as threats, insults, or intimidation violate the Geneva Convention. He added, "Nothing in this memorandum in any way restricts your existing authority to maintain good order and discipline among detainees."[6].

The Interrogation Rules of Engagement posted at Abu Ghraib stated: "[Interrogation] Approaches must always be humane . . . Detainees will NEVER be touched in a malicious or unwanted manner . . . the Geneva Conventions apply."[11] These rules were imported from the US operation in Afghanistan and echoed the 2003 memo by the Secretary of Defense. They stated: "Wounded or medically burdened detainees must be medically cleared prior to interrogation" and approved "Dietary manipulation (monitored by med)" for interrogation.[11] Defense Department memoranda define the latter as substituting hot meals to cold field rations rather than food deprivation but there are credible reports of food deprivation.[6,19,33]



Detainee at Abu Ghraib awaits medical attention from US military medics

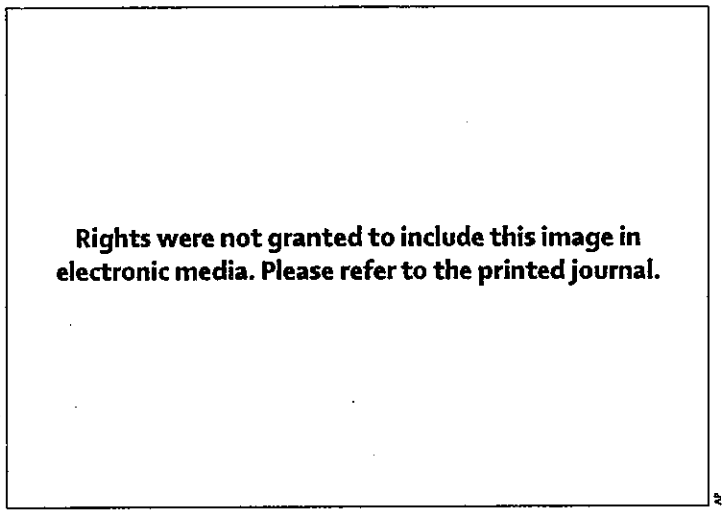
The legacy

Pentagon officials offer many reasons for these abuses including poor training, understaffing, overcrowding of detainees and military personnel, anti-Islamic prejudice, racism, pressure to procure intelligence, a few criminally-inclined guards, the stress of war, and uncertain lengths of deployment.[1,2,15,16,17] Fundamentally however, the stage for these offences was set by policies that were lax or permissive with regard to human rights abuses, and a military command that was inattentive to human rights.

Legal arguments as to whether detainees were prisoners of war, soldiers, enemy combatants, terrorists, citizens of a failed state, insurgents, or criminals miss an essential point. The US has signed or enacted numerous instruments including the UN Universal Declaration of Human Rights,[45] the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment,[46] UN Standard Minimum Rules for the Treatment of Prisoners,[34] the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment,[47] and US military internment and interrogation policies,[8–10] collectively containing mandatory and voluntary standards barring US armed forces from practicing torture or degrading treatments of all persons.

For example, the Universal Declaration of Human Rights states: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[45] The Geneva Convention states: "Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction . . . The following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons: Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; . . . Outrages upon personal dignity, in particular, humiliating and degrading treatment . . . No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind."[48] Furthermore, the US War Crimes Act says that US forces will comply with the Annex to the Hague Convention Respecting the Laws and Customs of War on Land and the Geneva Convention Relative to the Treatment of Prisoners of War both of which bar torture or inhumane treatment.[48–50]

Pentagon leaders testified that military officials did not investigate or act on reports by Amnesty International and the ICRC of abuses at Abu Ghraib and other coalition detention facilities throughout 2002 and 2003.[1,2,4,51,54] The command at Abu Ghraib and in Iraq was inattentive to human rights organisations' and soldiers' oral and written reports of abuses.[51] After the ICRC criticised the treatment of Abu Ghraib detainees, its access to detainees was curtailed.[1]



Detainee in solitary confinement attempts to reason with a guard at Abu Ghraib

The role of military medicine in these abuses merits special attention because of the moral obligations of medical professionals with regard to torture and because of horror at health professionals who are silently or actively complicit with torture. Active medical complicity with torture has occurred throughout the world. Physicians collaborated with torture during Saddam Hussein's regime.[52] Physicians' and nurses' professional organisations have created codes against participation in torture.[25–26,31,53,54] Physicians in Chile, Egypt, Turkey and other nations have taken great personal risks to expose state-sponsored torture.[25,26,55] Health professionals have created organisations including Physicians for Human Rights and Amnesty International's Health Professionals Network. Numerous non-medical groups have asserted that healers must be advocates for persons at risk of torture.[25,26,31,32,56]

Military personnel treating prisoners of war face a "dual loyalty conflict".[57] The Geneva Convention addresses this ethical dilemma squarely: "Although [medical personnel] shall be subject to the internal discipline of the camp . . . such personnel may not be compelled to carry out any work other than that concerned with their medical . . . duties."[48] By this standard, the moral advocacy of military medicine for the detainees of the war on terror broke down.

If Abu Ghraib is to leave a legacy of reform, it will be important to clarify how the breakdown occurred. The emerging evidence points to policy and operational failures. High-level Defense Department policies were inattentive to human rights and to the ethical obligations of medical care for detainees.[4] One policy empowered interrogators to evaluate and refuse the request of a

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AMERICAN PSYCHOLOGICAL ASSOCIATION

The Jim Lehrer Newshour

PBS TV, December 21, 2004, 7:00 PM

An Interview with Neil Lewis

BROADCAST EXCERPT

TERENCE SMITH: The new FBI memos released by the American Civil Liberties Union show that FBI Agents have lodged repeated reports about the physical and mental mistreatment of prisoners held in Iraq and Cuba. The abuses reportedly took place during the last two years and as recently as this past June. For more on the story, we're joined by Neil Lewis of the New York Times.

Neil, welcome.

NEIL LEWIS: Thank you.

TERENCE SMITH: These FBI memos were from agents who were sent down to supervise or observe in any event the interrogations carried out by military interrogators?

NEIL LEWIS: Well, in some cases, the FBI was tasked themselves with doing this. The FBI, for its own interests, had agents both at Guantanamo Bay, Cuba, and in Iraq, observing and sometimes participating in interrogations.

TERENCE SMITH: And to whom did they send these memos back reporting on what they saw and heard?

NEIL LEWIS: All of these memorandums were sent to their superiors in Washington to inform them of what they had either witnessed directly or understood was going on.

sense of the motivation of the interrogators? Did they believe they were about serious business here through which they could achieve significant intelligence?

NEIL LEWIS: I think so. And I think it's important. I mean, these are not people that were, I don't think, engaging in sadistic impulses. They believed it was an appropriate and proper mission; that it was awful work but it had a great purpose.

I think it's important to note that. Last month, after we reported in the Times that the International Committee of the Red Cross said that what was occurring at Guantanamo was tantamount to torture, the chairman of the Joint Chiefs of staff responded, I thought, very tellingly in a speech he gave the next day, where he said, "let's not forget these are people without any moral values down there."

Privately, when people talk to me about this, who were involved and generally approve of it in the government, one refrain is always, "Let's not forget the emotion and anger we felt in the immediate aftermath of Sept. 11." In other words, they're doing good work and important work that has to be done. So I think that's the pervasive belief of the people who are involved with this. It's obviously not the view of outsiders, and it's not the view of many FBI people who thought it wasn't even effective in getting information.

TERENCE SMITH: It's not reflected in what the White House had to say today. They said, "We're going to look into it."

NEIL LEWIS: Yes. They have shied away from any suggestion that President Bush has had any direct role in approving these harsh techniques.

TERENCE SMITH: Right. Is there anything in the memos or around them that reveals what the FBI agents who observed all this, what they thought of what they were seeing?

NEIL LEWIS: Yes. It's very fascinating. There are a whole bunch of themes. Some of the agents were appalled and expressed that. Some were professionally offended; saying it's not producing anything and it's just a wrong way to go about it. Some were very bureaucratic in the classic old-time FBI way, "protect the Bureau."

Some of the things that caused the greatest friction were the reports that the agents sent back that some of these military interrogators are posing as FBI agents when they're employing these coercive tactics and we're going to get stuck holding the bag if this ever gets out. So that was a source of great offense.

TERENCE SMITH: The interrogators, the military interrogators would identify themselves as FBI investigators?

NEIL LEWIS: Apparently so; this was a subject of great concern and colloquy between the military and FBI; it was never fully resolved, it appears.

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Medicine and War

By LEONARD S. RUBENSTEIN

Michael Gross's essay, "Bioethics and Armed Conflict: Mapping the Moral Dimensions of War and Medicine," is surely meant to provoke. In the wake of criticisms that American military physicians subordinated their ethical obligations to detained combatants at the behest of interrogators, Gross urges that in war the "interests of state and political community . . . may outweigh the considerations of patients' welfare." Indeed, the foil for Gross's argument is the World Medical Association's resolution, passed in 1982 and reaffirmed in October 2004, that medical ethics during armed conflict are identical to those in peacetime.

The core of Gross's argument is that during war, the principles of dignity, autonomy, and protection of life must be balanced against the principle of utility, which justifies war as a means of protecting the welfare of the nation-state and the community it represents. Although utility does not always trump other values, Gross recognizes that it may "run roughshod" over them. Moreover, Gross finds no grounds to exempt physicians from weighing these competing principles in decisions ranging from offering medical aid to a wounded soldier to participating in the development of chemical weapons. Rather, he says, in times of war, "every citizen, regardless of profession, has the same obligation to weigh reason of state and evaluate humanitarian principles." He therefore concludes that medicine in armed conflict poses difficult dilemmas for physicians.

We could debate Gross's proposition; adherence to traditional ethical rules may be essential to enable physicians to perform their core function. But more critical questions lurk beneath the surface: first, how to ground decisions when state demands conflict with traditional physician obligations, and second, how to protect physicians from being placed in an untenable position when subjected to these demands. Though the conflicts arise in civilian as well as in military life,[1] they receive far too little attention in the field.

Consider how physicians judge when to lend "their expertise to the prosecution of war, rather than simply to relieve the suffering it causes." Which principle should prevail, and under which circumstances? In most cases, the answer is reasonably clear, since armed conflict is governed by well-accepted principles of human rights and humanitarian law. For example, the Geneva Conventions prohibit the deliberate targeting of civilians and protect medical care for noncombatants, regardless of state interest. Physicians can and should use these standards as a sound guide to their own conduct, rather than balance patient needs against "military necessity."

Yet while Gross acknowledges the "inviolability" of humanitarian law, he treats it with an elasticity typical of a balancing approach. Take physician participation in torture. According to Gross, "Freedom from ill treatment may conflict with the right to life [of members of the larger society], leading a state to consider sacrificing the dignity of some to protect the lives of others. This is the hard problem of interrogational torture, and it often draws medical personnel into its web." But the decision is "hard" only if one rejects international humanitarian and human rights law, which holds that torture so deeply infringes on human dignity that it can never be justified, even in times of national emergency. A demand that a physician participate in torture presents no "dilemma"; it is always wrong. More generally, grounding physicians' ethical obligations in the requirements of human rights and humanitarian law provides a far surer guide to determining an appropriate ethical stance than suggesting that in every case they weigh human dignity against reasons of state.

In addition, asking physicians to engage in such balancing inevitably places them in untenable situations, since they lack both the competence and the facts needed to make a good decision. These problems inevitably force physicians to defer to commanders, which both denies physicians the ability to engage in ethical decisionmaking at all and exposes them to relentless pressures to conform to institutional demands. To avoid these problems, an entity such as a military medical ethics unit should resolve demands to subordinate fidelity to patients' interest to reasons of state, judging the urgency of the military need and assuring its consistency with international humanitarian law.

In the end, physicians need firm standards of conduct grounded in human rights law and institutional support to resist pressures from military organizations to breach them.

Leonard S. Rubenstein is the executive director of Physicians for Human Rights.

1. Physicians for Human Rights and Primary Health Care, University of Cape Town, Health Sciences Faculty, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* (Boston: Physicians for Human Rights 2002).

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Abuse led Navy to consider pulling Cuba interrogators

The Boston Globe

By Charlie Savage, Globe Staff | March 16, 2005

WASHINGTON -- Top US Navy officials were so outraged at abusive interrogation techniques being used at the Guantanamo Bay prison in late 2002 that they considered removing Navy interrogators from the operation, according to a portion of a recent Pentagon report that has not been made public.

A top Navy psychologist reported to his supervisor in December 2002 that interrogators at Guantanamo were starting to use "abusive techniques." In a separate incident that same month, the Defense Department's joint investigative service, which includes Navy investigators, formally "disassociated" itself from the interrogation of a detainee, after learning that he had been subjected to particularly abusive and degrading treatment.

The two events prompted Navy law enforcement officials to debate pulling out of the Guantanamo operation entirely unless the interrogation techniques were restricted. The Navy's general counsel, Alberto Mora, told colleagues that the techniques were "unlawful and unworthy of the military services."

The previously undisclosed events were disclosed at a hearing of the Senate Armed Forces Committee yesterday. The disclosures shed new light on the military services' objections to the Bush administration's policies on how to interrogate prisoners from the Afghanistan war.

Senator Carl Levin, Democrat of Michigan, said the events are outlined in the largely classified report on military detention and interrogation operations delivered last week by Navy Vice Admiral Albert T. Church. Levin did not disclose which techniques were used on prisoners that triggered the Navy's unusual concerns.

Levin said the Navy's expressions of outrage prompted Defense Secretary Donald H. Rumsfeld's decision in January 2003 to revoke an aggressive interrogation policy for Guantanamo detainees, according to the Church report. Rumsfeld then convened a Pentagon working group to examine interrogation issues more thoroughly. It came up with a more restricted interrogation policy in April 2003.

Specifically, the chain of events began when Dr. Michael Gelles, the chief psychologist of the Navy Criminal Investigative Service, or NCIS, completed a study of Guantanamo interrogations in December 2003 that included extracts of interrogation logs. Gelles reported to the service director, David Brant, that interrogators were using "abusive techniques and coercive psychological procedures."

The news prompted Brant to argue that if those aggressive practices continued, the agency would have to "consider whether to remain" at Guantanamo. At the same time, Mora, the Navy's general counsel, told colleagues that the techniques were "unlawful and unworthy of the military services," according to Levin's account.

That same month, Brant told Mora about a specific detainee who was "being subjected to physical abuse and degrading treatment." Mora took those concerns to the Defense Department's criminal investigative task force, which took the extraordinary step of deciding to disassociate itself from that detainee's interrogation.

Calling the Navy officials' concerns "very serious," Levin yesterday asked the commander of the US Southern Command, General Bantz Craddock, whether he could shed any further light on the matter at yesterday's hearing. Craddock has overseen Guantanamo since last year and was previously Rumsfeld's top uniformed military aide.

Craddock said he was unaware of the extent of the Navy's objections and had not read the full Church report, but the account matched the timeline of events as he recalled them. Guantanamo interrogators asked

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Boston Globe

Split seen on interrogation techniques

Navy official says many back stance against coercion

By Charlie Savage, Globe Staff | March 31, 2005

WASHINGTON -- A top Navy official whose warnings about "abusive" interrogation policies at Guantanamo Bay in December 2002 led the Navy to consider pulling its investigators out of the prison operation says his view that coercion does not produce quality information is shared by many specialists in the military and intelligence world.

In his first interview since his warnings were disclosed, Dr. Michael Gelles, the head psychologist for the Navy Criminal Investigative Service, said last week that many government intelligence professionals believe that coercive interrogation techniques -- inflicting pain or humiliation in order to extract information -- simply don't work.

And he expressed frustration that Bush administration policymakers have "dismissed" critics of coercive techniques as doves who are unwilling to do what is necessary to obtain information from terror suspects. In fact, Gelles said, many experienced interrogators are convinced coercive techniques do more harm than good.

The best way to extract intelligence from a captured Muslim extremist, Gelles said, is through "rapport-building" -- by engaging the suspect in conversations that play on his cultural sensitivities. Gelles said he and others have identified patterns of questioning that can elicit accurate information from Middle Easterners, but declined to disclose them for security reasons.

"We do not believe -- not just myself, but others who have to remain unnamed -- that coercive methods with this adversary are . . . effective," Gelles said. "If the goal is to get information, then using coercive techniques may be effective. But if the goal is to get reliable and accurate information, looking at this adversary, rapport-building is the best approach."

Gelles, the NCIS's top psychologist for 15 years, has participated in interrogations in Iraq, Afghanistan, and Guantanamo. He noted that the NCIS's experience with Muslim extremists predates Sept. 11, 2001, including probes into the 2000 bombing of the USS Cole in Yemen and the 1983 bombing of a Marine barracks in Lebanon.

The Navy granted Gelles permission to speak to the Globe after the recent disclosure of his role in prompting the first internal review of interrogation techniques at Guantanamo Bay. The Navy prohibited him from discussing specific experiences in Iraq, Afghanistan, or Cuba, or disclosing conversations with senior officials.

The memo also describes how FBI agents tried to persuade military commanders that coercive techniques were unreliable and recounts a "heated" video teleconference in which the FBI showed the military that certain intelligence produced by coercive techniques "was nothing more" than what the FBI got with traditional tactics: "[The Defense Department] finally admitted the information was the same the Bureau obtained. It still did not prevent them from continuing [their own] methods."

Gelles could not, under Navy rules, describe his own role in exposing possible abuses at Guantanamo Bay. But the most comprehensive military review of interrogations around the world cited him as sounding an early warning about "abusive techniques and coercive psychological procedures" in December 2002.

A month later, in response to the Navy's concerns, Defense Secretary Donald Rumsfeld rescinded an order allowing some of the most coercive techniques.

But in the two years that followed, accounts of the physical abuse -- and, in some cases, the deaths -- of military detainees under interrogation around the world have emerged, leading to a series of official investigations and ongoing lawsuits.

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2 of 2 DOCUMENTS

David Spaulding v. John Zimmerman and Others

Nos. 38,526, 38,529

Supreme Court of Minnesota

263 Minn. 346; 116 N.W.2d 704; 1962 Minn. LEXIS 789

August 3, 1962

PRIOR HISTORY: [***1]
Action in the Douglas County District Court for personal injuries arising out of a collision between an auto in which plaintiff was a passenger, driven by defendant John Zimmerman, and one driven by defendant Florian Ledermann and owned by defendant John Ledermann. The court, W. F. Rogosheske, Judge, vacated an order approving a prior settlement and denied the motions of defendants for summary judgment. Defendants appealed from said order.

DISPOSITION:

Affirmed.

LexisNexis(R) Headnotes

COUNSEL:

Rosengren, Rufer, Blatti & Hefte and *Richard L. Pemberton*, for appellants Ledermann.

Field, Arvesen & Donoho, for appellant Zimmerman.

Cummins, [***4] *Cummins & Gislason* and *David W. Nord*, for respondent.

JUDGES:

Thomas Gallagher, Justice. Mr. Justice Rogosheske took no part in the consideration or decision of this case.

OPINIONBY:

GALLAGHER

OPINION:

[*347] [**706] Appeal from an order of the District Court of Douglas County vacating and setting aside a prior order of such court dated May 8, 1957, [*348] approving a settlement made on behalf of David Spaulding on March 5, 1957, at which time he was a minor of the age of 20 years; and in connection therewith, vacating and setting aside releases executed by him and his parents, a stipulation of dismissal, an order for dismissal with prejudice, and a judgment entered pursuant thereto.

The prior action was brought against defendants by Theodore Spaulding, as father and natural guardian of David Spaulding, for injuries sustained by David in an automobile accident, arising out of a collision which occurred August 24, 1956, between an automobile driven by John Zimmerman, [**707] in which David was a passenger, and one owned by John Ledermann and driven by Florian Ledermann.

On appeal defendants contend that the court was without jurisdiction to vacate the settlement solely [***5] because their counsel then possessed information, unknown to plaintiff herein, that at the time he was suffering from an aorta aneurysm which may have resulted from the accident, because (1) no mutual mistake of fact was involved; (2) no duty rested upon them to disclose information to plaintiff which they could assume had been disclosed to him by his own physicians; (3) insurance limitations as well as physical injuries formed the basis for the settlement; and (4) plaintiff's motion to vacate the order for settlement and to set aside the releases was barred by the limitations provided in Rule 60.02 of Rules of Civil Procedure. n1

been taken shortly after the accident and at this time discovered that they disclosed the beginning of the process which produced the aneurysm. He promptly sent David to Dr. Jerome Grismer for an examination and opinion. The latter confirmed the finding of the aorta aneurysm and recommended immediate surgery therefor. This was performed by him at Mount Sinai Hospital in Minneapolis on March 10, 1959.

[*351] Shortly thereafter, David, having attained his majority, instituted the present action for additional damages due to the more serious injuries including the aorta aneurysm which he alleges proximately resulted from the accident. As indicated above, the prior order for settlement was vacated. In a memorandum made a part of the [***10] order vacating the settlement, the court stated:

"The facts material to a determination of the motion are without substantial dispute. The only disputed facts appear to be whether * * * Mr. Roberts, former counsel for plaintiff, discussed plaintiff's injuries with Mr. Arvesen, counsel for defendant Zimmerman, immediately before the settlement agreement, and, further, whether or not there is a causal relationship between the accident and the aneurysm.

"Contrary to the * * * suggestion in the affidavit of Mr. Roberts that he discussed the minor's injuries with Mr. Arvesen, the Court finds that no such discussion of the specific injuries claimed occurred prior to the settlement agreement on March 5, 1957.

"* * * the Court finds that although the aneurysm now existing is causally related to the accident, such finding is for the purpose of the motions only and is based solely upon the opinion expressed by Dr. Cain (Exhibit 'F'), which, so far as the Court can find from the numerous affidavits and [**709] statements of fact by counsel, stands without dispute.

* * *

"The mistake concerning the existence of the aneurysm was not mutual. For reasons which do not appear, plaintiff's [***11] doctor failed to ascertain its existence. By reason of the failure of plaintiff's counsel to use available rules of discovery, plaintiff's doctor and all his representatives did not learn that defendants and their agents knew of its existence and possible serious consequences. Except for the character of the concealment in the light of plaintiff's minority, the Court would, I believe, be justified in denying plaintiff's motion to vacate, leaving him to whatever questionable remedy he may have against his doctor and against his lawyer.

"That defendants' counsel concealed the knowledge they had is not disputed. The essence of the application of the above rule is the character [*352] of the concealment. Was it done under circumstances that defendants must be charged with knowledge that plaintiff did not know of the injury? If so, an enriching advantage was gained for defendants at plaintiff's expense. There is no doubt of the good faith of both defendants' counsel. There is no doubt that during the course of the negotiations, when the parties were in an adversary relationship, no rule required or duty rested upon defendants or their representatives to disclose this knowledge. [***12] However, once the agreement to settle was reached, it is difficult to characterize the parties' relationship as adverse. At this point all parties were interested in securing Court approval. * * *

"But it is not possible to escape the inference that defendants' representatives knew, or must be here charged with knowing, that plaintiff under all the circumstances would not accept the sum of $ 6,500.00 if he or his representatives knew of the aneurysm and its possible serious consequences. Moreover, there is no showing by defendants that would support an inference that plaintiff and his representatives knew of the existence of the aneurysm but concluded that it was not causally related to the accident.

"When the adversary nature of the negotiations concluded in a settlement, the procedure took on the posture of a joint application to the Court, at least so far as the facts upon which the Court could and must approve settlement is concerned. It is here that the true nature of the concealment appears, and defendants' failure to act affirmatively, after having been given a copy of the application for approval, can only be defendants' decision to take a calculated risk that the settlement [***13] would be final. * * *

"To hold that the concealment was not of such character as to result in an unconscionable advantage over plaintiff's ignorance or mistake, would be to penalize innocence and incompetence and reward less than full performance of an officer of the Court's duty to make full disclosure to the Court when applying for approval in minor settlement proceedings."

1. The principles applicable to the court's authority to vacate settlements made on behalf of minors and approved by it appear well [*353] established. With reference thereto, we have held that the court in its discretion may vacate such a settlement, even though it is not induced by fraud or bad faith, where it is shown that in the accident the minor sustained separate and distinct injuries which were not known or considered by the court at the time settlement was approved, *Larson v. Stowe, 228 Minn. 216, 36 N.W. (2d) 601, 8 A.L.R. (2d) 455; Wilson v. Davidson, 219 Minn. 42, 17 N.W. (2d) 31; Dasich v. La Rue Min. Co. 126 Minn. 194, 148 N.W. 45;*

would seem fairly clear that the principles governing this rule would be equally applicable here. In any event, there is nothing in the record which lends support to defendants' contention in this respect. Nowhere does it indicate that defendants had disclosed either to counsel for the plaintiff or to the court that insurance limitations were involved in the settlement; or that otherwise the court had knowledge thereof or gave consideration thereto at the time it approved the settlement. Under all such circumstances, [***19] no weight can be given to this argument.

Affirmed.

Westlaw.
221 F.3d 542
55 Fed. R. Evid. Serv. 443
(Cite as: 221 F.3d 542)

Briefs and Other Related Documents

United States Court of Appeals,
Fourth Circuit.

UNITED STATES of America, Plaintiff-Appellee,
v.
Theresa Marie SQUILLACOTE, a/k/a Tina, a/k/a Mary Teresa Miller, a/k/a The Swan, a/k/a Margaret, a/k/a Margit, a/k/a Margret, a/k/a Margrit, a/k/a Lisa Martin, a/k/a Resi, a/k/a Anne, Defendant-Appellant.
United States of America, Plaintiff-Appellee,
v.
Kurt Alan Stand, a/k/a Ken, a/k/a Junior, a/k/a Alan David Jackson, Defendant-Appellant.

Nos. 99-4088, 99-4089.

Argued March 3, 2000
Decided Aug. 11, 2000

Following jury trial, defendants, who were husband and wife, were convicted in the United States District Court for the Eastern District of Virginia, Claude M. Hilton, Chief District Judge, of conspiracy to transmit information relating to the national defense, attempted transmission of national defense information, and obtaining national defense information, and wife was also convicted of making false statements. Defendants appealed. The Court of Appeals, Traxler, Circuit Judge, held that: (1) electronic surveillance of defendants under Foreign Intelligence Surveillance Act (FISA) was supported by probable cause; (2) agents did not exceed scope of search warrant for defendants' residence; (3) evidence allegedly derived from privileged communications did not have to be suppressed; (4) foreign records were properly authenticated and were admissible as statements of coconspirator; and (5) challenged jury instructions were proper, but if any error existed, it was harmless.

Affirmed.

West Headnotes

[1] Telecommunications 515
372k515 Most Cited Cases

Finding that defendants, who had allegedly worked as agents for East Germany's foreign intelligence agency, were agents of a foreign power, as required for electronic surveillance of defendants under Foreign Intelligence Surveillance Act (FISA), was supported by probable cause, despite fact that East Germany was no longer in existence when applications were granted. Foreign Intelligence Surveillance Act of 1978, § 101 et seq., 50 U.S.C.A. § 1801 et seq.

[2] Telecommunications 511
372k511 Most Cited Cases

Subject to several exceptions, electronic surveillance of a foreign power or its agents may not be conducted unless the court established by the Foreign Intelligence Surveillance Act (FISA) authorizes it in advance. Foreign Intelligence Surveillance Act of 1978, § 101 et seq., 50 U.S.C.A. § 1801 et seq.

[3] Telecommunications 514.1
372k514.1 Most Cited Cases

Application to conduct electronic surveillance of foreign power or its agents, under the Foreign Intelligence Surveillance Act (FISA), must contain, among other things, a statement of reasons to believe that the target of the surveillance is a foreign power or agent of a foreign power, specified information on the implementation of the surveillance, and a certification from a high-ranking executive branch official stating that the official deems the information sought to be foreign intelligence information and that the information sought cannot be obtained by other means. Foreign Intelligence Surveillance Act of 1978, § 104(a)(7), 50 U.S.C.A. § 1804(a)(7).

[4] Telecommunications 514.1
372k514.1 Most Cited Cases

[4] Telecommunications 515
372k515 Most Cited Cases

and exhaustive, given the number and type of items that could be evidence of suspected espionage-related activities, and fact that house was cluttered and undergoing renovations. U.S.C.A. Const.Amend. 4.

[13] Criminal Law ⚷394.1(3)
110k394.1(3) Most Cited Cases

Although communications between suspect and her psychotherapists were privileged, government's interception of two such communications did not require suppression of evidence allegedly derived from such communications, since case did not involve compelled testimony, and privilege was not constitutionally-based. Fed.Rules Evid.Rule 501, 28 U.S.C.A.

[14] Witnesses ⚷304(1)
410k304(1) Most Cited Cases

If a privilege can be vindicated through a grant of immunity, as can, for example, the privilege against self-incrimination, then the witness may be compelled to testify if an adequate offer of immunity is made.

[15] Witnesses ⚷52(8)
410k52(8) Most Cited Cases

A spouse asserting the adverse spousal testimony privilege or the marital communications privilege may be compelled to testify if the prosecutor gives an adequate promise that the information will not be used against the other spouse.

[16] Witnesses ⚷184(1)
410k184(1) Most Cited Cases

Because testimonial exclusionary rules and privileges contravene the fundamental principle that the public has a right to every man's evidence, any such privilege must be strictly construed.

[17] Criminal Law ⚷444
110k444 Most Cited Cases

Official records of the former East Germany were properly authenticated, for purpose of admitting records in prosecution for various espionage-related offenses, even if records themselves were not signed and did not contain any attestation, where official of Federal Republic of Germany, which succeeded East Germany, certified that records were true and accurate copies of genuine East German records, and second official established that first official had signed certification and that first official was authorized to attest to records' authenticity. Fed.Rules Cr.Proc.Rule 27, 18 U.S.C.A; Fed.Rules Civ.Proc.Rule 44(a)(2), 28 U.S.C.A.; Fed.Rules Evid.Rule 902(3), 28 U.S.C.A.

[18] Criminal Law ⚷444
110k444 Most Cited Cases

To authenticate a foreign document, there first must be some indication that the document is what it purports to be, and, second, there must be some indication that the official vouching for the document is who he purports to be; thus, the proffered document must be executed by a proper official in his official capacity, or the genuineness of the document must be attested to by a proper official in his official capacity, and one of a specified group of foreign officials must issue a final certification attesting to the genuineness of signature and title of the person executing or attesting to the document, or of another official who has certified the signature and position of the person executing or attesting to the document. Fed.Rules Cr.Proc.Rule 27, 18 U.S.C.A; Fed.Rules Civ.Proc.Rule 44(a)(2), 28 U.S.C.A.; Fed.Rules Evid.Rule 902(3), 28 U.S.C.A.

[19] Criminal Law ⚷444
110k444 Most Cited Cases

Rules for authenticating foreign documents do not require the official attesting to the genuineness of the documents or records to have possession or custody of the proffered documents, to be an expert in handwriting analysis, or to have been associated with the foreign government at the time the documents were created. Fed.Rules Cr.Proc.Rule 27, 18 U.S.C.A; Fed.Rules Civ.Proc.Rule 44(a)(2), 28 U.S.C.A.; Fed.Rules Evid.Rule 902(3), 28 U.S.C.A.

[20] Criminal Law ⚷423(1)
110k423(1) Most Cited Cases

Foreign documents evidencing defendants' relationship with agency of the former East Germany were admissible as nonhearsay statements of a coconspirator, in prosecution for various espionage-related offenses, in view of evidence that defendants conspired with agents and officers of East Germany, and that documents were produced during course of, and in furtherance of, conspiracy, notwithstanding government's inability to identify the declarants. Fed.Rules Evid.Rule 801(d)(2)(E), 28 U.S.C.A.

[21] Criminal Law ⚷1153(1)
110k1153(1) Most Cited Cases

Court of Appeals reviews for an abuse of discretion the

[32] Criminal Law 37(3)
110k37(3) Most Cited Cases

While mild forms of persuasion do not amount to inducement to commit a crime, certain kinds of persuasion or appeals to sympathy can be considered inducements for purposes of an entrapment defense.

[33] Criminal Law 37(4)
110k37(4) Most Cited Cases

Even when the evidence clearly establishes that the government's actions induced the defendant to commit the crime, an entrapment defense fails if the defendant was predisposed to commit the crime.

[34] Criminal Law 37(1)
110k37(1) Most Cited Cases

The defense of entrapment is not of a constitutional dimension.

[35] Criminal Law 1172.1(4)
110k1172.1(4) Most Cited Cases

Even if district court violated rule by giving different version of jury instruction on entrapment at trial than version that court informed parties it would give, defendants were not prejudiced thereby, and were not entitled to new trial, despite claim that defendants tailored their argument to original instruction. Fed.Rules Cr.Proc.Rule 30, 18 U.S.C.A.

[36] Criminal Law 836
110k836 Most Cited Cases

Purpose of rule requiring district court to inform counsel of its proposed action upon the requests for specific jury instructions prior to their arguments to the jury is to require the district court to inform the trial lawyers in a fair way what the instructions are going to be in order to allow counsel the opportunity to argue the case intelligently to the jury. Fed.Rules Cr.Proc.Rule 30, 18 U.S.C.A.

[37] Criminal Law 1173.1
110k1173.1 Most Cited Cases

Violation of rule requiring district court to inform counsel of its proposed action upon the requests for specific jury instructions prior to their arguments to the jury requires reversal only if the defendant can establish actual prejudice. Fed.Rules Cr.Proc.Rule 30, 18 U.S.C.A.

[38] Criminal Law 37(5)
110k37(5) Most Cited Cases

Defendant cannot claim an entrapment defense based upon the purported inducement of a third party who is not a government agent if the third party is not aware that he is dealing with a government agent.

[39] Criminal Law 37(2.1)
110k37(2.1) Most Cited Cases

[39] Criminal Law 37(4)
110k37(4) Most Cited Cases

The defense of entrapment is generally applicable only in cases where a government agent induces the commission of a crime by a defendant who was not predisposed to commit the crime; thus, there is no defense of private entrapment, and a defendant who was induced to commit a crime by a private party, without any government involvement, cannot claim that he was entrapped.

[40] Conspiracy 48.2(2)
91k48.2(2) Most Cited Cases

Evidence established that defendants and government witness were involved in single conspiracy to compromise information related to national defense, such that defendants were not entitled to requested multiple-conspiracy instruction, in view of their shared contacts and training, even if defendants and witness were not always aware of each other's activities, and, even if erroneous, failure to give multiple-conspiracy instruction was harmless, as it was unlikely that jury would have transferred evidence from one defendant to another defendant involved in an unrelated conspiracy, and evidence of multiple conspiracies was weak.

[41] Conspiracy 48.2(2)
91k48.2(2) Most Cited Cases

A multiple conspiracy instruction is not required unless the proof at trial demonstrates that defendants were involved only in separate conspiracies unrelated to the overall conspiracy charged in the indictment.

[42] Conspiracy 24(2)
91k24(2) Most Cited Cases

A single conspiracy exists where there is one overall agreement, or one general business venture.

[43] Conspiracy 24(2)
91k24(2) Most Cited Cases

Stand's HVA activities consisted primarily of recruiting other agents. In 1976, Stand invited James Michael Clark, a college friend, to travel with him to Germany. Stand introduced Clark to an HVA operative, who introduced him to Ziemer. Ziemer invited Clark to join his organization, which he described as performing intelligence work on behalf of East Germany and other socialist countries, as well as "liberation movements" in Asia, Latin America, and Africa. J.A. 903. Clark agreed. Sometime between 1979 and 1981, Stand brought his wife Theresa Squillacote into the fold, and she too became what Ziemer described as an "informal collaborator[ ]." J.A. 703. At some point, Squillacote's relationship with Ziemer became more than professional, and they had an affair that lasted until 1996.

The HVA devoted substantial resources to the training of Stand, Squillacote, and Clark. They traveled to many countries, including East Germany and Mexico, to meet with their "handlers." They received training on detecting and avoiding surveillance, receiving and decoding messages sent by shortwave radio from Cuba, mailing and receiving packages through the use of "accommodation" addresses, using codewords and phrases, using a miniature camera to photograph documents, and removing classified markings from documents. HVA records indicate that the three conspirators were together paid more than $40,000 between 1985 and 1989, primarily as reimbursement for travel expenses.

As part of his "operational plan" devised with Ziemer, J.A. 925, Clark moved to Washington, D.C., and obtained a master's degree in Russian. For a time Clark worked for a private company in a position that required him to obtain a security clearance. He later obtained a position with the United States Army, in its environmental law division, which also required a security clearance. Clark had friends who worked for the State Department, and through them he obtained numerous ***549** classified documents that he turned over to the HVA.

Squillacote and Stand also moved to Washington, D.C., and she went to law school at the HVA's suggestion. Squillacote first followed in her father's footsteps by becoming an attorney for the National Labor Relations Board. When she realized that she had taken a career path that was not "in the best direction," J.A. 2213, she began trying to "move [her] professional work more in line with the commitments that [she] had made." J.A. 1682. To that end, Squillacote used her father's connections to obtain an unprecedented temporary detail from the NLRB to the House Armed Services Committee. In 1991, Squillacote obtained a permanent job as an attorney in the Department of Defense, eventually becoming the Director of Legislative Affairs in the Office of the Undersecretary of Defense (Acquisition Reform), a position that required a security clearance and provided access to valuable information. During her tenure with the federal government, Squillacote applied for numerous government jobs, including positions with the Central Intelligence Agency, the National Security Agency, United States Army, Navy, and Air Force, and the Departments of State, Commerce, Energy, and Treasury. Apparently it was not until she began working for the Department of Defense that Squillacote gained access to the kind of information sought by her handlers. [FN1] However, by that time, East Germany had collapsed.

> FN1. The government's evidence established that it was not unusual for the HVA to recruit agents and then, "over the course of years, ... seek to install [the agent] into a sector where [the agent] will be of use." J.A. 718.

After the fall of the Berlin Wall, Ziemer began working with the KGB, the Soviet Union's intelligence agency. Ziemer maintained his relationships with Stand, Squillacote, and Clark during this time, and they, too, became involved with the KGB. Stand, Squillacote, and Clark each traveled overseas to meet with Ziemer during the period after the collapse of East Germany. Ziemer instructed the conspirators to purchase Casio digital diaries with interchangeable memory cards. The conspirators, Ziemer, and their KGB contacts communicated with each other by exchanging memory cards.

In April 1992, Ziemer and another former HVA official were arrested and ultimately convicted for their post-unification intelligence activities with the KGB. Stand, Squillacote, and Clark became understandably concerned about their personal safety after Ziemer's arrest. They knew that "western services" were looking for two men and one woman operating out of Washington, D.C., and that the western services were aware of code names they had used. J.A. 2240. However, they believed that Ziemer and other former HVA officials would not compromise their identities. When Ziemer was released from prison in September 1992, Stand, Squillacote, and Clark re-established a system of communication with him, one purpose of which was to keep everyone informed about any threats to their safety.

From the beginning of their involvement with the

"friendly overture," and "act[ing] professional and somewhat aloof yet responsive to her moods. The initial meet should be brief and leave [Squillacote] beguiled and craving more attention." J.A.2065.

The false flag letter received by Squillacote in September 1996 served its intended purpose. Unaware of any FBI involvement, Squillacote and Stand were thrilled about the letter, and Squillacote began enthusiastically making plans for a trip to New York City to meet the South African emissary.

In October 1996, Squillacote met with an undercover FBI agent posing as a South African intelligence officer. She had face-to-face meetings with the agent a total of four times, including one meeting where she brought Stand and her two children. Several letters were also exchanged, including a letter that Squillacote wrote at the request of the undercover agent describing her previous activities with Ziemer. In these meetings and letters, Squillacote expressed her enthusiasm for her new South African connection and her hope for a productive collaboration.

Throughout her association with the undercover agent, Squillacote discussed the possibility of bringing Ziemer and other former East German contacts into the operation. In December 1996, she contacted Ziemer to see if he was interested in the operation. According to Squillacote, Ziemer's response was "[y]es, yes, yes, yes, yes!" J.A. 1939.

At the second meeting with the undercover agent on January 5, 1997, Squillacote presented the agent with four classified documents she had obtained from the Department of Defense. Although the agent had never requested any documents or classified information from Squillacote, she explained that one day when she and her secretary were alone in her office, she decided to "score what [she] could score." J.A. 509. In fact, she had obtained one of the documents even before her *first* meeting with the undercover agent. The documents Squillacote gave to the undercover agent were: (1) "Defense Planning Guidance for Fiscal Year 1997 through 2001," J.A. 499, a numbered document, classified "secret," with restricted dissemination; (2) "Defense Planning Guidance Scenario Appendix" for 1998 through 2003, J.A. 501, a numbered document classified at the "secret" level, which forbade reproduction or further dissemination without authorization; (3) "Defense Planning Guidance, Fiscal Years 1996 through 2001, Final For Comment Draft," J.A. 504, which was classified "secret," with restricted dissemination; and (4) an untitled CIA intelligence report classified "secret," with restricted dissemination. Three of the documents Squillacote gave to the undercover agent were copies; the "Scenario Appendix" was an original that Squillacote said would not be missed. These documents formed the basis of the charges against Squillacote and Stand.

Shortly after this meeting, Squillacote quit her job with the Department of Defense, a political maneuver she hoped would put her in position for a more prestigious job. [FN2] Nonetheless, Squillacote continued *552 meeting and corresponding with the undercover agent for several more months, until she and Stand were arrested in October 1997. A search of their home uncovered a wealth of incriminating evidence, including a miniature camera, a Casio digital diary and memory cards, and an extra copy of two of the documents given to the undercover agent.

FN2. However, Squillacote explained to the undercover agent that her involvement in the political maneuvering and her decision to quit were primarily motivated by her "joint efforts" with the undercover agent. Squillacote believed that her former Department of Defense boss might be named Deputy Secretary of Defense and that she would be able to follow her former employer back into the Department. Squillacote described this scenario as "the big time," noting that if it worked out, there would be a "straight f---ing line," J.A. 515, presumably to the Secretary of Defense. This scenario never came to pass.

Clark eventually pleaded guilty to a single charge of conspiring to commit espionage, and he testified for the government at the trial of Squillacote and Stand. At trial, the government introduced certain HVA records, including "true name" cards showing the names and addresses of Stand, Squillacote, and Clark, as well as documents listing some of their code names and the names of the operations to which they were assigned. The HVA records listed Squillacote as a "[d]evelopmental agent" whose target was the "U.S. central government" and described Squillacote as trustworthy. J.A.2028. The records described Stand as reliable, and listed him as a "[s]ource with direct access," with a target of "U.S. union/organization, direct/upper level, IBFG union, U.S.A." J.A.2034. Clark was listed as a "[s]ource with direct access," whose activities were targeted against the "Defense Ministry NATO Country FRG USA." J.A.2010. The records also described Clark as reliable. Other than the four documents passed to the undercover agent, the government presented no evidence establishing that Squillacote or Stand had previously supplied classified

issue: They contend that the surveillance was improper because there was no probable cause to believe that Squillacote or Stand were agents of a foreign power. We disagree.

Under FISA, an agent of a foreign power is any person who "knowingly engages in clandestine intelligence gathering activities for or on behalf of a foreign power, which activities involve or may involve a violation of the criminal statutes of the United States." 50 U.S.C.A. § 1801(b)(2)(A). One who knowingly aids and abets another engaging in such clandestine intelligence activities, or one who knowingly conspires with another to engage in the clandestine intelligence activities, is also considered an agent of a foreign power. *See* 50 U.S.C.A. § 1801(b)(2)(D). A "United States person" may not be determined to be an agent of a foreign power "solely upon the basis of activities protected by the first amendment to the Constitution of the United States." 50 U.S.C.A. § 1805(a)(3)(A).

FISA provides that the district court must review *in camera* and *ex parte* the FISA application and other materials necessary to rule upon a defendant's suppression motion "if the Attorney General files an affidavit under oath that disclosure or an adversary hearing would harm the national security of the United States." 50 U.S.C.A. § 1806(f). Because the Attorney General filed such an affidavit in this case, the district court reviewed the applications and other materials *in camera,* and the documents were not disclosed to counsel for the Appellants. *See* *5550 U.S.C.A. § 1806(f) (The district court "may disclose to the aggrieved person, under appropriate security procedures and protective orders, portions of the application, order, or other materials relating to the surveillance only where such disclosure is necessary to make an accurate determination of the legality of the surveillance.").

After reviewing the applications, the district court concluded that each of the more than 20 FISA applications established probable cause to believe that the Appellants were agents of a foreign power. We have reviewed *de novo* the relevant materials, and likewise conclude that each FISA application established probable cause to believe that Squillacote and Stand were agents of a foreign power at the time the applications were granted, notwithstanding the fact that East Germany was no longer in existence when the applications were granted. *See* 50 U.S.C.A. § 1801(a) (defining "foreign power"); 50 U.S.C.A. § 1801(b) (defining "agent of a foreign power"). We are also satisfied that the Appellants were not targeted solely because of any protected First Amendment activities in which they may have engaged. Given the sensitive nature of the information upon which we have relied in making this determination and the Attorney General's conclusion that disclosure of the underlying information would harm the national security, it would be improper to elaborate further. *See United States v. Isa,* 923 F.2d 1300, 1304 (8th Cir.1991) (finding probable cause to authorize FISA surveillance and declining to comment further on the probable cause issue where the Attorney General filed an affidavit and claim of privilege).

[5] Accordingly, we reject the Appellants' contention that the FISA surveillance was illegal. In addition, because the documents submitted by the government were sufficient for the district court and this Court to determine the legality of the surveillance, we also deny the Appellants' request for disclosure of the FISA materials. *See United States v. Belfield,* 692 F.2d 141, 147 (D.C.Cir.1982) ("The language of section 1806(f) clearly anticipates that an *ex parte, in camera* determination is to be the rule. Disclosure and an adversary hearing are the exception, occurring *only* when necessary.").

B.

The Appellants also sought to suppress the evidence obtained during the search of their home, including the miniature camera, the digital diary and memory cards, a doll with a roll of miniature film hidden inside, and copies of two of the documents Squillacote passed to the undercover agent. The Appellants contend that the search was conducted in flagrant disregard of the express terms of the warrant, and that the district court therefore erred in denying their suppression motion.

The warrant authorizing the search of the Appellants' home stated that the government was to search the residence "on or before October 10, 1997 (not to exceed ten days) ..., serving this warrant and making the search [ ]in the daytime--6:00 A.M. to 10:00 P.M." J.A. 330. [FN5] The search extended over six days, with two FBI agents remaining at the house each night. It is the presence of the FBI agents in the home after 10:00 p.m. that forms the basis of the Appellants' suppression arguments.

FN5. *See* Fed.R.Crim.P. 41(c)(1) (A search warrant "shall be served in the daytime, unless the issuing authority ... authorizes its execution at times other than daytime."); Fed.R.Crim.P. 41(h) (defining "daytime" as "the hours from 6:00 a.m. to 10:00 p.m.").

(1)

the FBI exceeded the scope of the warrant, we still would not conclude that the government's actions required suppression of all the evidence seized during the search. As a general rule, if officers executing a search warrant exceed the scope of the warrant, only the improperly-seized evidence will be suppressed; the properly-seized evidence remains admissible. *See* United States v. Jones, 31 F.3d 1304, 1314 (4th Cir.1994); *see also* Horton v. California, 496 U.S. 128, 140, 110 S.Ct. 2301, 110 L.Ed.2d 112 (1990) ("If the scope of the search exceeds that permitted by the terms of a validly issued warrant or the character of the relevant exception from the warrant requirement, the subsequent seizure is unconstitutional without more. Thus, in the case of a search incident to a lawful arrest, if the police stray outside the scope of an authorized ... search they are already in violation of the Fourth Amendment, and *evidence so seized will be excluded* ...." (emphasis added) (alteration and internal quotation marks omitted)). However, "[i]n extreme circumstances even properly seized evidence may be excluded when the officers executing the warrant exhibit a flagrant disregard for its terms." United States v. Ruhe, 191 F.3d 376, 383 (4th Cir.1999) (internal quotation marks omitted).

[11] The extraordinary remedy of blanket suppression of all evidence seized "should be used only when the violations of the warrant's requirements are so extreme that the search is essentially transformed into an impermissible general search." United States v. Chen, 979 F.2d 714, 717 (9th Cir.1992); *accord* United States v. Medlin, 842 F.2d 1194, 1199 (10th Cir.1988). Thus, in the few cases where blanket suppression has been ordered, most involved the seizure by law enforcement officials of large quantities of evidence clearly not within the scope of the warrant. *See* United States v. Foster, 100 F.3d 846, 848 (10th Cir.1996); Medlin, 842 F.2d at 1196, 1199; United States v. Rettig, 589 F.2d 418, 420-21 (9th Cir.1978).

In this case, however, the Appellants do not contend that any of the evidence seized by the government was beyond the scope of the warrant or that, by remaining in the house after 10:00 p.m., the government impermissibly converted the warrant into a general warrant. Instead, the Appellants complain only about the manner by which the government executed the warrant, a complaint that is inadequate to justify the severe remedy of blanket suppression.

First, we note that when a warrant authorizes only a daytime search, some courts have held that there is no violation of the terms of the warrant if the search is commenced in the daytime, even if it continues into the night. *See, e.g.*, United States v. Young, 877 F.2d 1099, 1104-05 (1st Cir.1989); United States v. Burgard, 551 F.2d 190, 193 (8th Cir.1977); United States v. Joseph, 278 F.2d 504, 505 (3rd Cir.1960) (per curiam). Because the search of the Appellants' home was commenced in the daytime, as required by the warrant, the FBI agents reasonably could have believed (if their actions after 10:00 p.m. could be considered a search) that it was proper to continue the search into the night. Second, the FBI reasonably could have concluded that it was proper to station agents inside the house after the search was suspended each evening in order to guard against the possible destruction *557 of evidence. *Cf.* United States v. Gagnon, 635 F.2d 766, 769 (10th Cir.1980) (concluding that when agents executing a search warrant discovered more marijuana than they could transport, the agents were responsible for preserving the evidence, and properly remained on the scene overnight and resumed the search the next day, when a truck arrived that could carry away the drugs). The reasonableness of the agents' conduct makes it difficult to conclude that they flagrantly disregarded the terms of the warrant.

Under these circumstances, even if the FBI's actions amounted to technical violations of the terms of the warrant, the violations were relatively minor and were "motivated by considerations of practicality rather than by a desire to engage in indiscriminate 'fishing.' " United States v. Tamura, 694 F.2d 591, 597 (9th Cir.1982). Thus, any violations are wholly insufficient to require blanket suppression of all the evidence seized under the warrant.

(2)

[12] In a last-ditch effort to invalidate the search, the Appellants contend that if the government did in fact stop searching each night at 10:00, then the evidence must still be suppressed because the government did not obtain a new warrant for each successive day of searching. Again we disagree.

It is beyond dispute that FBI agents entered the Appellants' home on six consecutive days to search for evidence. However, given the number and type of items that can be evidence of espionage-related activities, the search was necessarily extensive and exhaustive. *See* United States v. Wuagneux, 683 F.2d 1343, 1352 (11th Cir.1982) ("[T]he magnitude of a search is insufficient, by itself, to establish a constitutional violation; rather, the relevant inquiry is whether the search and seizures were reasonable under all the circumstances.... [G]iven the complexity of the crimes under investigation and the fact that they would be detected primarily if not exclusively through analysis

any evidence derived from the privileged information should have been suppressed and that they were entitled to a hearing to vindicate the principles set forth by the Supreme Court in *Kastigar v. United States*, 406 U.S. 441, 92 S.Ct. 1653, 32 L.Ed.2d 212 (1972). We, however, conclude that *Kastigar* simply is not applicable to this case.

In *Kastigar*, the issue was whether a witness who asserts his Fifth Amendment privilege against self-incrimination may be compelled to testify "by granting immunity from the use of compelled testimony and evidence derived therefrom ('use and derivative use' immunity), or whether it is necessary to grant immunity from prosecution for offenses to which compelled testimony relates ('transactional' immunity)." *Id.* at 443, 92 S.Ct. 1653. The Court concluded that a grant of "immunity from use and derivative use is coextensive with the scope of the privilege against self-incrimination, *559 and therefore is sufficient to compel testimony over a claim of the privilege." *Id.* at 453, 92 S.Ct. 1653. The Court noted that if a witness who has been granted use and derivative use immunity is subsequently prosecuted, the prosecutors bear " 'the burden of showing that their evidence is not tainted by establishing that they had an independent, legitimate source for the disputed evidence.' " *Id.* at 460, 92 S.Ct. 1653 (quoting *Murphy v. Waterfront Comm'n of New York Harbor*, 378 U.S. 52, 79 n. 18, 84 S.Ct. 1594, 12 L.Ed.2d 678 (1964)). The Court further explained that "[t]his total prohibition on use provides a comprehensive safeguard, barring the use of compelled testimony as an 'investigatory lead,' and also barring the use of any evidence obtained by focusing investigation on a witness as a result of his compelled disclosures." *Id.* at 460, 92 S.Ct. 1653 (footnote omitted).

We agree with the Appellants that Squillacote's conversations with her psychotherapists are privileged. *See Jaffee v. Redmond*, 518 U.S. 1, 15, 116 S.Ct. 1923, 135 L.Ed.2d 337 (1996) ("[W]e hold that confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence."). The question, then, is whether the mere existence of this privileged information brings to bear the full weight of *Kastigar*, as Appellants apparently contend.

[14] Contrary to the Appellants' view, a *Kastigar* analysis is not triggered by the existence of evidence protected by a privilege, but instead by the government's effort to compel a witness to testify over the witness's claim of privilege. *See United States v. Hubbell*, 530 U.S. 27, ----, 120 S.Ct. 2037, 2045, 147 L.Ed.2d 24 (2000) (stating that *Kastigar* "particularly emphasized the critical importance of protection against a future prosecution based on knowledge and sources of information obtained from *the compelled testimony* " (emphasis added) (internal quotation marks omitted)); *United States v. McHan*, 101 F.3d 1027, 1035 (4th Cir.1996) ("Whether the oral use-immunity agreement at issue in this case is subject to the full *Kastigar* protections is doubtful because McHan voluntarily cooperated with the government."); *United States v. Eliason*, 3 F.3d 1149, 1152 (7th Cir.1993) (Under *Kastigar*, "if a defendant is able to establish through relevant evidence that he gave compelled testimony in a court proceeding based upon a promise of immunity, the government must come forth with evidence that the information it purports to use against the defendant came from a source independent of the defendant's immunized testimony."); *United States v. Gutierrez*, 696 F.2d 753, 756 n. 6 (10th Cir.1982) ("Because [the defendant], with full knowledge of her rights, voluntarily agreed to make a statement, the constitutional principles enunciated in *Kastigar* ... are inapplicable to her claim."). If the privilege can be vindicated through a grant of immunity--as can, for example, the privilege against self-incrimination--then the witness may be compelled to testify if an adequate offer of immunity is made.

[15] To this extent then, we agree with the Appellants' assertion that *Kastigar*-like protections may be required in cases involving testimony compelled over the assertion of a non-constitutional privilege. For example, a spouse asserting the adverse spousal testimony privilege or the marital communications privilege may be compelled to testify if the prosecutor gives an adequate promise that the information will not be used against the other spouse. *See, e.g., In re Grand Jury*, 111 F.3d 1083, 1087 (3rd Cir.1997) ("[O]nce the government grants immunity that eliminates the possibility that the testimony will be used to prosecute the witness's spouse, the witness spouse may no longer invoke the testimonial privilege."); *In re Grand Jury Subpoena of Ford*, 756 F.2d 249, 252 (2nd Cir.1985) (concluding that husband could be held in contempt for refusing to testify before the grand jury about actions of his *560 wife where the prosecutor promised that "no grand jury testimony elicited from [the husband] would be used, either directly or indirectly, against [his] wife"). However, because the government's right to compel testimony in the face of a claim of privilege is the issue at the heart of *Kastigar*, its protections do not apply in cases where there is privileged evidence, but no compelled testimony.

[16] Moreover, because "[t]estimonial exclusionary rules and privileges contravene the fundamental

44(a)(2) of the Rules of Civil Procedure but is broader in applying to public documents rather than being limited to public records.").

> FN9. The procedure set forth in Rule 44(a)(2) is applicable in criminal proceedings by virtue of Rule 27 of the Federal Rules of Criminal Procedure. *See* Fed.R.Crim.P. 27 ("An official record ... may be proved in the same manner as in civil actions.").

In this case, the government presented a certification from Dirk Dorrenberg, the director of the counterespionage and protective security department of the Bundesamt fur Verfassungsschutz, the counter-intelligence service for the unified Federal Republic of Germany ("FRG"). In his certification Dorrenberg stated that the FRG is the legal successor to East Germany and that he had the "authority to make this certification by virtue of [his] official position and area of expertise." J.A.1982. Dorrenberg stated that he had compared the HVA documents introduced by the government to "actual duplicates" of the original records, and he certified that the government's copies were "true and correct copies" of "genuine and authentic records" of the HVA. J.A.1983-84. Dorrenberg also certified that the signature of Lothar Ziemer appearing on some of the records was "genuine and authentic." J.A.1984. The government also presented a final certification from Manfred Bless, an FRG representative "assigned and accredited to the United States as a Counselor, Political Section, of the Embassy of the Federal Republic of Germany, in Washington, D.C." J.A.1980. In this final certification, Bless certified that Dorrenberg held the position claimed in the Dorrenberg certification and that Dorrenberg was authorized to make the certification.

These certifications comply in all respects with the requirements of Rule 44(a)(2) and Rule 902(3). Therefore, whether the documents are considered official documents or official records, the district court quite properly concluded that the government adequately authenticated the HVA documents.

The Appellants, however, contend that the certification process of Rule 902(3) is intended to confirm the signature or attestation *contained in the offered document.* According to the Appellants, if the document being offered into evidence does not contain a signature, a self-serving declaration of authenticity is meaningless. Thus, the Appellants contend that many of the HVA documents are not subject to self-authentication under the rules because the documents themselves are not signed or do ***562** not contain an attestation. This argument is without merit.

Nothing in Rule 44(a)(2) or in Rule 902(3) requires that the documents themselves be signed or contain an attestation within the body of the document. The rules are written in the alternative--foreign documents may be authenticated by a certification from the official executing the document *or* by an official attesting to the document. To "attest" means to "affirm to be correct, true, or genuine." *American Heritage College Dictionary* 89 (3d ed.1997). Thus, so long as a proper official attests that the proffered document is true and genuine, it simply does not matter whether the document itself is signed or contains its own attestation.

As noted above, Rule 44(a)(2) also requires a final certification regarding the signature and position "(i) of the attesting person, or (ii) of any foreign official whose certificate of genuineness of signature and official position relates to the attestation or is in a chain of certificates of genuineness of signature and official position relating to the attestation." Fed.R.Civ.P. 44(a)(2); *see also* Fed.R.Evid. 902(3)(A) & (B). Seizing on these requirements, the Appellants contend that neither the Dorrenberg certification nor the Bless certification establish that "Dorrenberg is an official 'whose certificate of genuineness of signature and official position relates to the execution or attestation' or that his certificate is in a 'chain of certificates of genuineness of signature and official position relating to the execution or attestation.' " Brief of Appellants at 73. This argument is likewise without merit, as it is premised upon a fundamental misapprehension of the requirements for the authentication of foreign documents.

[18] An examination of Rule 44(a)(2) and Rule 902(3) reveals two requirements for the authentication of a foreign document. First, there must be some indication that the *document* is what it purports to be. Thus, the proffered document must be executed by a proper official in his official capacity, or the genuineness of the document must be attested to by a proper official in his official capacity. *See* Fed. R.Civ.P. 44(a)(2); Fed.R.Evid. 902(3); *see also* *United States v. Doyle*, 130 F.3d 523, 545 (2d Cir.1997) (noting that the authentication provisions of the Rules of Evidence are not concerned with establishing the truth of information contained in proffered documents, but only with "assuring that evidence is what it purports to be"). Second, there must be some indication that the *official* vouching for the document is who he purports to be. Thus, the rules require that one of a specified group of foreign officials must issue a final certification attesting to the genuineness of signature and title of the person

them reliable and admissible under Rule 801(d)(2)(E), notwithstanding the government's inability to identify the declarants. *See United States v. Cruz*, 910 F.2d 1072, 1081 n. 10 (3d Cir.1990) ("Unidentifiability [of the declarant] may be important in some situations, but when the statement itself and the surrounding circumstances provide sufficient evidence of reliability, unidentifiability will not be particularly important.").

[23] We therefore conclude that the HVA records were properly authenticated and were properly admitted as statements of co-conspirators. The Appellants' complaints about the reliability of the HVA records, including the fact that the government purchased the documents from unidentified sources, merely go to the weight to be accorded the records by the jury, and not to the admissibility of the records. *Cf. Koziy*, 728 F.2d at 1322 (noting that the appellant's contention that Ukranian police documents were forgeries "fails to go their admissibility, but rather to the weight of the evidence"). [FN10]

FN10. Another of the Appellants' complaints about the documents centers around the fact that the documents were not contained in the records of the Gauck Commission, the post-unification repository for MfS documents. The Gauck Commission, however, became the repository only of the "documents that were still there upon dissolution of the MfS, which occurred during December of 1989. The MfS had gone through several transitional phases, which resulted in a good number of documents having disappeared." J.A. 823A. That the documents were not among the Gauck Commission's records does not prevent them from being admitted at trial, but is simply another credibility question to be resolved by the jury.

IV.

Finally, the Appellants raise numerous issues in connection with the district court's instructions to the jury. Their challenges involve the district court's instructions on their entrapment defense, the court's failure to include an instruction on multiple conspiracies, and its explanation to the jury of "information relating to the national defense."

A.

[24][25][26] The Appellants raise several issues in connection with the district court's refusal to give their entrapment instructions. There are two elements to the affirmative defense of entrapment: "government inducement and the defendant's lack of predisposition to commit the crime." *United States v. Sligh*, 142 F.3d 761, 762 (4th Cir.1998); *see United States v. Russell*, 411 U.S. 423, 436, 93 S.Ct. 1637, 36 L.Ed.2d 366 (1973) ("It is only when the Government's deception actually implants the criminal design in the mind of the defendant that the defense of entrapment comes into play."). "Where the Government has induced an individual to break the law and the defense of entrapment is at issue ... the prosecution must prove beyond reasonable doubt that the defendant was disposed to commit the criminal act prior to first being approached by Government agents." *Jacobson v. United States*, 503 U.S. 540, 548-49, 112 S.Ct. 1535, 118 L.Ed.2d 174 (1992). [FN11]

FN11. The government contends that the Appellants were not entitled to an entrapment instruction. However, because the government did not oppose the Appellants' request for an entrapment instruction at trial and the instruction was in fact given, we believe it proper to consider the Appellants' challenges to the entrapment instruction.

(1)

[27][28] The Appellants first contend that the district court erred by rejecting their proposed predisposition charge. To determine whether the district court's failure to give the requested charge is reversible error, we must determine whether the instruction "(1) was correct; (2) was not substantially covered by the court's charge to the jury; and (3) dealt with some point in the trial so important, that failure to give the requested instruction seriously impaired the defendant's ability to conduct *565 his defense." *United States v. Lewis*, 53 F.3d 29, 32 (4th Cir.1995) (internal quotation marks omitted).

The instruction requested by the Appellants stated that, for the government to carry its burden of proving predisposition, "the Government must prove beyond a reasonable doubt that Ms. Squillacote had a predisposition prior to the first time the Government approached her.... However, you may not find a predisposition based on any of Ms. Squillacote's conduct that was induced by the Government." J.A. 1579. The Appellants contend that their instruction is based on *Jacobson*, and that the instruction thus is a correct statement of the law.

J.A. 1445-47 (emphasis added). By informing the jury that the defendants must have a "previous disposition" that existed "before encountering the law enforcement officer," the instruction given sufficiently conveyed to the jury the requirement that the Appellants must have been predisposed to commit the crimes before they were contacted by the undercover agent. *See United States v. Lorenzo*, 43 F.3d 1303, 1306-07 (9th Cir.1995) (finding no error in jury charge explaining that the government must prove that the defendant "has a previous intent or disposition" because the jury charge also explained that the disposition must have existed "before encountering the law enforcement officers or their agents" (internal quotation marks omitted)). [FN12]

FN12. The Appellants, however, contend that the government's first contact with Squillacote--the phony Kasrils letter--was an "approach," not an "encounter," because encounter can only mean a face-to-face meeting. Thus, the Appellants argue that by instructing the jury to consider predisposition that existed before the first encounter with the government, the jury may have concluded that Squillacote became predisposed to commit the crimes only after receiving the Kasrils letter, but still rejected the entrapment defense because the disposition arose before Squillacote met the undercover agent for the first time. While it may have been preferable for the instructions to use "approach" or "contact" rather than "encounter," we believe that the district court's instruction sufficiently directed the jury's focus to the proper time frame for determining the existence of Squillacote's predisposition, particularly since there was no dispute that the government's first contact was the Kasrils letter. *See, e.g., United States v. Heater*, 63 F.3d 311, 326 (4th Cir.1995) ("We will not reverse a conviction based on improper jury instructions as long as the instructions given by the district court, as a whole, included the substance of the defendant's requested ... charge.").

(2)

[30] The Appellants next contend that the district court erred by refusing to instruct the jury that, in order to prove *567 predisposition, the government must prove that Squillacote was "in a position by virtue of his or her acquaintances, experience, occupation, or training to commit the offenses without the government's help or involvement." J.A. 1577. In essence, the Appellants contend that the question of predisposition includes a "positional" element--that is, a defendant is pre-disposed to commit a crime only if the defendant was in the position to commit the crime without assistance from the government.

The Appellants' "positional" argument is based on the Seventh Circuit's decision in *United States v. Hollingsworth*, 27 F.3d 1196 (7th Cir.1994) (en banc), in which a sharply divided court held that "[p]redisposition is not a purely mental state, the state of being willing to swallow the government's bait. It has positional as well as dispositional force." *Id.* at 1200. The court determined that defining predisposition only as willingness, without including an element of readiness, was inconsistent with the Supreme Court's decision in *Jacobson:*

> [H]ad the Court in *Jacobson* believed that the legal concept of predisposition is exhausted in the demonstrated willingness of the defendant to commit the crime without threats or promises by the government, then Jacobson was predisposed, in which event the Court's reversal of his conviction would be difficult to explain. The government did not offer Jacobson any inducements to buy pornographic magazines or threaten him with harm if he failed to buy them. It was not as if the government had had to badger Jacobson for 26 months in order to overcome his resistance to committing a crime. He *never* resisted.

Id. at 1199.

Whether predisposition includes a readiness element has yet to be considered in this circuit, although the Ninth Circuit has rejected the *Hollingsworth* formulation. *See United States v. Thickstun*, 110 F.3d 1394, 1398 (9th Cir.1997) ("We read *Jacobson* not as creating a requirement of positional readiness but as applying settled entrapment law. The inference that the government's methods had persuaded an otherwise law-abiding citizen to break the law, coupled with the absence of evidence of predisposition, established entrapment as a matter of law under the existing two-part test. It was not necessary for the court to expand the entrapment defense, nor is there language in the opinion indicating that it did so."). [FN13] We need not, however, decide whether predisposition includes a positional element because even under the *Hollingsworth* formulation, Squillacote clearly was in the position to commit the crimes with which she was charged.

FN13. A panel of the Fifth Circuit followed *Hollingsworth* and concluded that

*569 [32] While "mild forms of persuasion" do not amount to inducement, *United States v. Daniel*, 3 F.3d 775, 779 (4th Cir.1993), we agree with the Appellants that certain kinds of persuasion or appeals to sympathy can be considered inducements for purposes of an entrapment defense. *See, e.g., United States v. Montanez*, 105 F.3d 36, 39 (1st Cir.1997) ("By omitting [from its entrapment instruction] any 'sympathy' examples, the trial court may well have left the jury with the mistaken impression that coercion is a necessary element of entrapment and, in this case, such a misunderstanding could well have affected the outcome"); *United States v. Jackson*, 700 F.2d 181, 191 (5th Cir.1983) (noting that to support an entrapment defense, "the government conduct must include an element of persuasion or mild coercion, such as ... pleas based on need, sympathy, or friendship."). The instruction proposed by the Appellants, however, failed to explain to the jury that mild forms of persuasion cannot be considered inducement. To this extent, the Appellants' instruction was not a correct statement of the law, and the district court properly rejected it.

More importantly, however, we disagree with the Appellants' assertion that the instruction given by the district court was inadequate. While the instruction did not specifically state that inducement could be accomplished through "persuasion," neither did it limit inducement to coercion, which, according to the Appellants, was the thrust of the government's argument to the jury. Instead, the instruction required the jury to determine "the nature and the degree of the inducement" from all of the evidence presented at trial. J.A. 1446. The parties skillfully argued their views of the case during closing arguments, and the instruction gave the jury sufficient latitude to conclude that the government's actions amounted to inducement. Thus, the district court did not err by refusing to give the Appellants' requested instruction. *See Chaudhry v. Gallerizzo*, 174 F.3d 394, 408 (4th Cir.) ("The test of the adequacy of jury instructions is whether the jury charge, construed as a whole, adequately states the controlling legal principle without misleading or confusing the jury."), *cert. denied*, 528 U.S. 891, 120 S.Ct. 215, 145 L.Ed.2d 181 (1999).

[33][34] Moreover, even if we were to conclude that the district court's inducement instruction was inadequate, that conclusion would not require reversal. "[T]he principal element in the defense of entrapment [is] the defendant's predisposition to commit the crime." *Russell*, 411 U.S. at 433, 93 S.Ct. 1637. Thus, even when the evidence clearly establishes that the government's actions induced the defendant to commit the crime, an entrapment defense fails if the defendant was predisposed to commit the crime. *See Jacobson*, 503 U.S. at 548-49, 112 S.Ct. 1535; *see also United States v. Cervante*, 958 F.2d 175, 178 (7th Cir.1992) ("The entrapment analysis ends without inquiry into government inducement if the defendant was predisposed to commit the charged conduct."); *United States v. Osborne*, 935 F.2d 32, 37 (4th Cir.1991) ("[I]f the defendant's predisposition is established, the defense of entrapment may not be based on government misconduct."); *see also Brace*, 145 F.3d at 255 ("The Government acknowledges that it induced [the defendant] to launder money. Therefore, at issue is whether the evidence was sufficient to prove, beyond a reasonable doubt, that [the defendant] was predisposed to do so."). Thus, any error in the district court's instructions as to the government's inducement of Squillacote would be harmless if we can conclude that the jury could only have found that Squillacote was predisposed to commit the crimes with which she was charged. *See United States v. Hastings*, 134 F.3d 235, 241 (4th Cir.1998) ("When, over a proper objection, a district court erroneously instructs the jury on an element of the offense, the error may be disregarded as harmless if a reviewing court can determine, beyond a reasonable doubt, that a correctly instructed jury would have reached the same conclusion."); *see also* *570 *United States v. Jackson*, 72 F.3d 1370, 1378 (9th Cir.1995) (concluding, under a plain error review, that a faulty entrapment instruction did not require reversal of the defendant's conviction because "the evidence virtually compels a finding that the defendant was pre-disposed"); *United States v. Jannotti*, 729 F.2d 213, 225 (3d Cir.1984) (concluding that error in the district court's entrapment instructions did not require reversal where the government presented overwhelming proof of the defendants' predisposition). [FN14]

FN14. The defense of entrapment "is not of a constitutional dimension." *Russell*, 411 U.S. at 433, 93 S.Ct. 1637. Thus, as the Third Circuit noted in *Jannotti*, 729 F.2d at 225, it would seem that we would not be required to find any error in the district court's entrapment instructions harmless beyond a reasonable doubt, as we would with a constitutional error. *See Chapman v. California*, 386 U.S. 18, 87 S.Ct. 824, 17 L.Ed.2d 705 (1967). Nonetheless, even under the beyond-a-reasonable-doubt standard, we find any error to be harmless.

In our view, the evidence of Squillacote's predisposition can only be described as overwhelming. The government's evidence established that

Before closing arguments, the district court held a charge conference. As to the entrapment defense, the court stated that it "plan[ned] to simply give the Devitt and Blackmar [FN16] instruction on entrapment." J.A. 1344. After the court rejected the Appellants' requested entrapment instructions, some of which have already been discussed in this opinion, the Appellants stated that they "would prefer the full '92 Devitt and Blackmar to the Government's proposed charge on entrapment." J.A. 1354. The court agreed to give the Devitt & Blackmar charge.

> FN16. *See* 1 Edward J. Devitt et al., *Federal Jury Practice and Instructions* § 19.04 (4th ed.1992).

The Devitt & Blackmar entrapment instruction sought by the Appellants states, in relevant part:

> A defendant may not be convicted of this crime, however, if that person was entrapped by the government to the acts charged.
>
> A person is entrapped when that person has no previous intent or disposition or willingness to commit the crime charged and is induced *or persuaded* by law enforcement officers [or by their agents] to commit the offense.
>
> . . . . .
>
> In determining the question of entrapment, the jury should consider all of the evidence received in this case concerning the intentions and disposition of the defendant before encountering the law enforcement officers [or their agents] as well as the nature and the degree of the inducement *or persuasion* provided by the law enforcement officers [or their agents].

*572 1 Devitt & Blackmar, § 19.04 (emphasis added).

The instructions actually given by the district court, however, were largely the government's proposed instructions, and the instructions deviated somewhat from the Devitt & Blackmar model instruction. The court did not include the introductory paragraph explaining that a defendant cannot be convicted if entrapped, and the district court did not include the words "persuaded" or "persuasion" in its charge. The Appellants contend that the district court violated Rule 30 of the Rules of Criminal Procedure when it deviated from the promised charge.

[36][37] Rule 30 requires that the district court "inform counsel of its proposed action upon the requests [for specific jury instructions] prior to their arguments to the jury." Fed.R.Crim.P. 30. The purpose of the rule is "to require the district court to inform the trial lawyers in a fair way what the instructions are going to be in order to allow counsel the opportunity to argue the case intelligently to the jury." *United States v. Horton*, 921 F.2d 540, 547 (4th Cir.1990) (internal quotation marks omitted). A violation of Rule 30 requires reversal only if the defendant can establish actual prejudice. *See id.*; *United States v. Burgess*, 691 F.2d 1146, 1156 (4th Cir.1982).

Although we question whether the district court in fact violated Rule 30 by failing to deliver the Devitt & Blackmar instruction verbatim, we will nonetheless assume that a violation occurred. The question, then, is whether the Appellants suffered any prejudice.

The Appellants contend they were prejudiced by the district court's deviation from the Devitt & Blackmar charge because, based on their expectation that the persuasion language would be included, they argued persuasion to the jury and invited the jury to listen for persuasion in the court's entrapment instruction. [FN17] The Appellants contend that the district court's failure to give the expected jury instruction damaged their credibility with the jury, and effectively bolstered the government's credibility because the entrapment instructions discussed by the government during its closing were ultimately given by the district court. We disagree.

> FN17. The Appellants also contend that by failing to include the opening paragraph of the Devitt & Blackmar instruction, the court failed to inform the jury that entrapment was a complete defense to the charges. This argument is without merit. The district court informed the jury that entrapment was asserted as a defense and that the government bore the burden of proving beyond a reasonable doubt that the Appellants were predisposed to committing the crimes. Viewing the charge as a whole, we conclude that the district court adequately instructed the jury as to the effect of the asserted defense. *See Chaudhry*, 174 F.3d at 408.

Although counsel for Appellants did mention persuasion in closing argument, the reference to the court's impending instructions was rather general. [FN18] There was no explicit promise that the court would define persuasion, nor was there any attempt by the attorney to define persuasion for the jury. In addition, although the government's closing argument did focus primarily on whether Squillacote was coerced

*574*Crisp v. United States*, 262 F.2d 68, 69 (4th Cir.1958) (per curiam). These cases make it clear that, in the Fourth Circuit, a defendant cannot claim an entrapment defense based upon the purported inducement of a third party who is not a government agent if the third party is not aware that he is dealing with a government agent. *Accord Thickstun*, 110 F.3d at 1398; *United States v. Martinez*, 979 F.2d 1424, 1432 (10th Cir.1992). The district court, therefore, committed no error by refusing to give the requested instruction.

B.

[40] The Appellants also contend that the district court erred when it determined that the evidence established only a single conspiracy and thus refused to give the Appellants' requested multiple-conspiracy instruction. We disagree.

[41][42][43] "A multiple conspiracy instruction is not required unless the proof at trial demonstrates that appellants were involved *only* in separate conspiracies *unrelated* to the overall conspiracy charged in the indictment." *United States v. Kennedy*, 32 F.3d 876, 884 (4th Cir.1994) (first emphasis added) (internal quotation marks omitted). "A single conspiracy exists where there is one overall agreement, or one general business venture. Whether there is a single conspiracy or multiple conspiracies depends upon the overlap of key actors, methods, and goals." *United States v. Leavis*, 853 F.2d 215, 218 (4th Cir.1988) (citations and internal quotation marks omitted).

The government's evidence established that Squillacote, Stand, and Clark were involved in a single conspiracy to compromise information related to this country's national defense. Stand, who was recruited by Ziemer, recruited both Clark and Squillacote. Ziemer was the primary handler for Stand, Squillacote, and Clark, and the three received largely the same training and used the same methods of communicating with their East German contacts. After the collapse of East Germany, the three continued their relationships with Ziemer, which expanded to include the KGB. With the knowledge of the other conspirators, Squillacote also sought to develop new contacts with others who might be interested in what the group had to offer. Stand was aware of Squillacote's letter to Kasrils, as well as her meetings with the undercover agent. In fact, Stand helped Squillacote remove the classified markings from the documents she provided to the agent. Clark was likewise aware of the letter she wrote to Kasrils, and Squillacote sought to involve Stand, Clark, and Ziemer in the operation after she was contacted by the undercover agent.

In our view, this evidence is more than sufficient to support the finding of a single conspiracy. That Squillacote, Stand, and Clark were not always aware of the others' activities is part of the standard operating procedure for those engaged in espionage and would not prevent the jury from determining that a single conspiracy existed. *See United States v. Banks*, 10 F.3d 1044, 1054 (4th Cir.1993) ("[O]ne may be a member of a conspiracy without knowing its full scope, or all its members, and without taking part in the full range of its activities or over the whole period of its existence."); *United States v. Johnson*, 54 F.3d 1150, 1154 (4th Cir.1995) (concluding that evidence established a single conspiracy even if the members of the conspiracy did not know each other or had limited contact with each other).

While it is possible that Squillacote's South African foray could be viewed as separate from the original conspiracy, it was certainly closely related to the conspiracy charged in the indictment, a conspiracy in which the evidence overwhelmingly established the involvement of Squillacote and Stand. Therefore, because the evidence did not establish that the Appellants were involved "only in 'separate conspiracies *unrelated* to the overall conspiracy charged in the indictment,' " *Kennedy*, 32 F.3d at 884, the district court properly refused to instruct *575 the jury on multiple conspiracies. *See id.* [FN20]

FN20. The Appellants make much of Clark's testimony on cross-examination that he did not have an agreement with the Appellants to commit espionage, that he lost contact with the Appellants for a several years in the late 1970s and early 1980s, and that he was not involved in the South African effort. Given that Clark pleaded guilty to the charge that he conspired with the Appellants to commit espionage, it seems unlikely that the jury would have found this testimony particularly persuasive. In any event, to accept this argument would require us to consider only Clark's testimony and to ignore the other evidence tending to show the existence of a single conspiracy or multiple, but still related, conspiracies, which of course we cannot do at this stage of the proceedings.

[44] Moreover, even if the evidence in this case warranted a multiple conspiracy instruction, the district court's failure to give the instruction amounts to reversible error only if the Appellants can establish that they were "prejudiced by the variance between the

official government documents carry with them an imprimatur of legitimacy and authenticity. Thus, even if speculative information similar to that contained in a document appears in the press, that should not prevent a conviction based upon the unauthorized release of the document itself. The government therefore contends that the district court properly instructed the jury that closely held information must be made available to the public by the government before it loses its status as national defense information.

The statutes at issue unfortunately provide no guidance on the question of what kind of information may be considered related to or connected with the national defense. The task of defining "national defense" information thus has been left to the courts.

The Supreme Court considered the possible limitations on national defense information in *Gorin v. United States*, 312 U.S. 19, 61 S.Ct. 429, 85 L.Ed. 488 (1941). *Gorin* involved sections one and two of the Espionage Act of 1917, the predecessor to the statutes at issue here. The defendants in *Gorin* argued that national defense information under the Espionage Act must be limited to information related to the places and things specified in section 1(a) of the Espionage Act. [FN21] According to the *Gorin* defendants, failure to so limit the *577 Act rendered it unconstitutionally vague and infringed "upon the traditional freedom of discussion of matters connected with national defense which is permitted in this country." *Id.* at 23, 61 S.Ct. 429.

> FN21. Section 1(a) of the Espionage Act prohibited entering into, flying over, or "otherwise obtain[ing] information concerning any vessel, aircraft, work of defense, navy yard, naval station, submarine base, coaling station, fort, battery, torpedo station, dockyard, canal, railroad, arsenal, camp, factory, mine, telegraph, telephone, wireless, or signal station, building, office, or other place connected with the national defense," if those actions were for the purpose of obtaining national defense information intended to be used "to the injury of the United States, or to the advantage of any foreign nation." *Gorin*, 312 U.S. at 21 n. 1, 61 S.Ct. 429. Section 793(a) contains essentially identical language.

The Supreme Court rejected this argument, and adopted the government's definition of national defense as "a generic concept of broad connotations, referring to the military and naval establishments and the related activities of national preparedness." *Id.* at 28, 61 S.Ct. 429. The Court concluded that the Act's requirement that the information be intended to be "used to the injury of the United States, or to the advantage of any foreign nation" provided a sufficient limitation on the reach of the Act:

> This [language] requires those prosecuted to have acted in bad faith. The sanctions apply only when scienter is established. *Where there is no occasion for secrecy, as with reports relating to national defense, published by authority of Congress or the military departments, there can, of course, in all likelihood be no reasonable intent to give an advantage to a foreign government.*

Id. (emphasis added).

In *United States v. Heine*, 151 F.2d 813 (2nd Cir.1945), the Second Circuit further considered the question of whether an espionage conviction can be based upon the dissemination of publicly-available information. In *Heine*, the defendant, during the early stages of World War II, provided a German corporation with reports about the aviation industry in the United States. All of the information provided by the defendant "came from sources that were lawfully accessible to anyone who was willing to take the pains to find, sift and collate it." *Id.* at 815. Relying on *Gorin*, the court concluded that the dissemination of information that the government had never kept secret could not support an espionage conviction:

> [I]t is obviously lawful to transmit any information about weapons and munitions of war which the services had themselves made public; and if that be true, we can see no warrant for making a distinction between such information, and information which the services have never thought it necessary to withhold at all. There can, for example, be no rational difference between information about a factory which is turning out bombers, and to which the army allows access to all comers, and information about the same bombers, contained in an official report, or procured by a magazine through interviews with officers. The services must be trusted to determine what information may be broadcast without prejudice to the "national defense," and their consent to its dissemination is as much evidenced by what they do not seek to suppress, as by what they utter.... "Information relating to the national defense," whatever else it means, cannot therefore include that kind of information, and so far as Heine's reports contained it, they were not within the section.

Id. at 816. The court, therefore, reversed the defendant's conviction on the espionage count. *Id.* at 817.

Truong, however, contains no discussion of the central issue here--that is, when can information contained in a closely-held document be considered publicly available--and it does not stand for the broad proposition urged by the Appellants that the presence in the public domain of snippets of unattributed and unverified information similar to that contained in official documents closely held by the government prevents a prosecution based on the transmission of the document itself.

To accept the Appellants' argument would effectively require the government to prove, at least as to some piece of information contained in the document, that no person anywhere in the world had ever publicly speculated about that information. Requiring that kind of "proof of a negative" would unduly hamper the government's ability to protect sensitive information and would render successful prosecutions in cases involving closely-held documents nearly impossible. *Cf. United States v. Richardson*, 30 M.J. 1239, 1244 (A.C.M.R.1990) (per curiam) ("The appellant contends that evidence of record is insufficient to support his espionage conviction because there is no evidence of record that the information he conveyed to 'Vladimir' was not accessible to the public.... Contrary to the appellant's interpretation of the dicta in *Gorin* and the decision in *Heine*, the offense of espionage does not require proof of a negative averment. These decisions stand for the simple proposition that an inference of bad faith on the part of the accused may not be justified where the 'national defense information' alleged in the charge is generally accessible to the public or has been published to the public at large by the United States government."), *rev'd on other grounds*, 33 M.J. 127 (C.M.A.1991). The mere fact that similar but unofficial information is publicly available does not automatically remove information in closely-held documents from the realm of "national defense" information, as the Appellants' requested instruction suggests. *Truong* 's shorthand summary of the instruction given in that case simply cannot be read as silently but yet so fundamentally changing the law as established in *Gorin*, *Heine*, and *Dedeyan*.

We reject the Appellants' reliance on *United States v. Morison*, 844 F.2d 1057 (4th Cir.1988), for the same reason. In *Morison*, the defendant again challenged section 793 as unconstitutionally vague. This court again rejected that argument, concluding that the jury instructions defining wilfulness and national defense information were sufficient to overcome any vagueness problem. *See id.* at 1071-72. The national defense instruction given in *Morison* stated, in relevant part, that "the government must prove that the documents or the photographs are closely held in that [they] ... have not been made public and are not available to the general public." *Id.* (ellipses and alteration in original). This instruction is consistent with *Gorin*, *Heine*, and *Dedeyan* in that it explains that information made public by the government as well as information never protected by the government is not national defense information. While the "not available to the general public" language of the charge could arguably provide some support for the Appellants' argument, we again decline to interpret this brief reference to the jury charge as silently working a fundamental change in the law.

Here, the district court instructed the jury that the information made public by the government could not be considered national defense information, nor could publicly available information that the government has never protected. These instructions were consistent with the teachings of *Gorin*, *Heine*, and *Dedeyan*. *580 Although the court did not give the additional *Dedeyan* instruction (which was not set out in this Court's opinion in *Dedeyan*), that instruction was not requested by either party, and its omission does not render improper the instructions given. We therefore reject the Appellants' challenge to the district court's national defense instructions. [FN23]

FN23. As previously discussed, the Supreme Court in *Gorin* concluded that the Espionage Act's scienter requirement sufficiently limited the reach of the Act so as to overcome the defendant's vagueness challenge. However, *Dedeyan*, *Truong*, and *Morison* focused on the jury instructions defining national defense information when rejecting the vagueness or overbreadth challenges, even though the Supreme Court in *Gorin* found no reversible error in the much more general national defense instructions that were given in that case. *See Gorin*, 312 U.S. at 30-31, 61 S.Ct. 429. To this extent, *Dedeyan*, *Truong*, and *Morison* arguably offer more protection to defendants than required by *Gorin*.

V.

After carefully reviewing the record and considering the arguments of the parties, we find no reversible error in the proceedings below. Accordingly, the convictions of the Appellants are hereby affirmed.

AFFIRMED

29

On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness

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Objective: This article explores the clinical, legal, and ethical problems that typically occur when a psychotherapist serves as both a treating clinician and forensic evaluator (or expert witness) in the same case. Method: The professional literature, ethics codes, opinion surveys, and the changing economic and institutional contexts of psychotherapy are reviewed in order to identify obstacles to widespread recognition of this straightforward ethical issue. The processes of psychotherapy and forensic evaluation are then analyzed so as to reveal fundamental incompatibilities between the psychotherapist's clinical and legal functions. Results: Attempting to treat and evaluate the same person typically creates an irreconcilable role conflict. This role conflict manifests itself in different conceptions of truth and causation, different forms of alliance, different types of assessment, and different ethical guidelines. Conclusions: Although circumstances sometimes compel a practitioner to assume the dual role of treater and evaluator, the problems that surround this practice argue for its avoidance whenever possible.
(Am J Psychiatry 1997; 154:448–456)

Should psychotherapists serve as expert witnesses for their patients? Psychotherapists of all disciplines need to confront the potential clinical, legal, and ethical problems involved in combining the roles of treating clinician and forensic evaluator. As clinicians find themselves drawn into proliferating, often ambiguously defined contacts with the legal system, clarity in role definitions becomes crucial.

DEFINITIONS

The term "therapist" refers to a clinician hired by the patient or the patient's family to provide psychotherapy; therapists treat "patients" or "clients." A "fact witness" testifies as to direct observations that he or she has made; a fact witness does not offer expert opinions or draw conclusions from the reports of others. Thus, a therapist who serves as a fact witness testifies as to observations of the patient during therapy and the immediate conclusions (such as diagnosis and prognosis) drawn from those observations. These conclusions are offered not as an opinion but simply as a report of what the therapist thought, did, and documented during therapy.

An "expert witness" (who may also act as a forensic consultant) is a paid consultant who chooses to become involved in the case and is retained by an attorney, judge, or litigant to provide evaluation and testimony to aid the legal process. Unlike a fact witness, an expert may offer opinions about legal questions. This role typically involves participation in a trial. Forensic experts deal with "examinees" or "evaluees" rather than with patients or clients. They do not attempt to form a doctor-patient relationship with their subjects.

COMMON SCENARIOS

Several common scenarios may prompt a clinician to wear the two hats of treater and expert on behalf of the same person. A patient may have suffered a traumatic incident (such as a criminal assault or an automobile accident) during or before therapy, and litigation may ensue. A patient may become involved in child custody litigation. A referral may come from an attorney osten-

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Sound as they are, these guidelines not only lack detailed elaboration, but are unenforceable, since the American Academy of Psychiatry and the Law refers ethics complaints to APA, which has not adopted the Academy's ethical guidelines. APA has, however, issued a comparable position statement with respect to employment-related psychiatric examinations (19).

For psychologists, the ethical boundary is less sharply drawn. The American Psychological Association's code of ethics (20) allows psychologists to serve simultaneously as consultant or expert and as fact witness in the same case, provided that they "clarify role expectations" (p. 1610). Guidelines developed specifically for forensic psychologists by the American Psychology-Law Society and Division 41 of the American Psychological Association (21) address the "potential conflicts of interest in dual relationships with parties to a legal proceeding" (p. 659). These guidelines, however, allow broader latitude than those of the American Academy of Psychiatry and the Law.

Surveys of Forensic Psychiatrists

Surveys of forensic psychiatrists' ethical concerns reveal a surprising lack of consensus on the treater/expert role conflict. In a 1986 survey of forensic psychiatrists who belonged to the American Academy of Forensic Sciences, two-thirds considered "conflicting loyalties" a significant ethical issue, yet only three of 51 respondents specifically mentioned the treater/evaluator role conflict (22). In 1989, with the ethical guidelines of the American Academy of Psychiatry and the Law recently in place, members of both the American Academy of Forensic Sciences and the American Academy of Psychiatry and the Law rated the treater/expert scenario least significant among 28 potential ethical problems listed (23). (Only 14.5% of the members of the American Academy of Forensic Sciences perceived this situation to represent an ethical problem, while 71.0% did not.)

In 1991, among 12 controversial ethical guidelines proposed for consideration, members of the American Academy of Psychiatry and the Law gave least support to extending the Academy's warning against performing forensic evaluations on current patients to include former patients as well (24). The authors of the survey attributed this opposition, as well as continuing disagreement even about the impropriety of evaluating current patients, to a "recognition of the dual treater-evaluator role sometimes being both necessary and appropriate" (p. 245). Thus, during the past decade, any increased scrutiny of this dual role has confronted the reasoning that "multiple agency and a balancing of values have become a necessary part of all current psychiatric practice, not only for forensic psychiatry" (p. 246).

CONTEXTS AND COMPLICATIONS

The resistance of highly trained specialists to such an ethical principle becomes understandable when set against the changing landscape of psychotherapy. Limited reimbursements are making extended psychodynamic exploration a luxury. Moreover, with many patients' problems being seen as manifestations of extrapsychic (environmental, institutional, economic, legal, or political) conditions, the therapist is becoming a social worker, mobilizing resources on the patient's behalf; a gatekeeper, unlocking the doors of managed care; a detective, obtaining useful information; or an agent of social control, protecting others from the patient. The therapist, thus placed in an advocate's or case manager's role, is expected to influence external outcomes rather than simply accompany the patient on an inner exploration.

Mental health services today are commonly delivered in public institutions (such as state hospitals and prisons) where therapists are accountable to society as well as to the patient. In these settings confidentiality may be breached from the outset, and therapy often has a built-in forensic component. Even private psychotherapy takes on a forensic dimension in the case of reportable offenses or threats to third parties. To some degree, then, the treater/expert role conflict has become incorporated into the therapist's job description. "Pure," disinterested psychotherapy is compromised as legal, economic, and social responsibilities multiply and fewer clinicians really practice independently. More and more, the therapist is working for institutions, corporations, and society.

Given these conditions, rigorous separation of the treater and evaluator roles in public practice has been called unworkable and even inadvisable (25). Nonetheless, a strong reaffirmation of role clarity is still called for, especially in light of an epidemic of aggressive legal advocacy by therapists. The proliferation of cases of "recovered memory," for instance, with their dubious methodologies and controversial outcomes, shows that some therapists are losing sight of the essential distinction between subjective experience and historical reconstruction (26). These therapists, perhaps driven by unexamined countertransference (2), step out of role when they urge their patients to take to court issues that might better be resolved in therapy.

For didactic clarity, the following discussion is cast in the language of traditional psychotherapy. Nonetheless, it applies to many forms of psychiatric and psychological treatment, including psychopharmacological, behavioral, and cognitive therapies. Since questions of trust, rapport, and confidentiality enter into all clinical treatment, the evaluator's role of gathering and reporting information from multiple sources external to the dyad is always in conflict with the treater's role.

TRUTH AND CAUSATION

Clinical and forensic undertakings are dissimilar in that they are directed at different (although overlapping) realities, which they seek to understand in correspondingly different ways.

world rather than the external world. In the course of a therapeutic alliance the patient must often accept personal responsibility as a condition of change. This contrasts strongly with the plaintiff's quest to assign responsibility to others in order to achieve recompense, cost sharing, or equity—as well as vindication. In therapy, the patient frequently must learn to understand and forgive; these considerations are largely irrelevant to the forensic evaluee and antithetical to the retributive thrust of litigation.

In building a treatment alliance the psychotherapist attempts to ally with that part of the patient that seeks to change, to give up psychopathological symptoms, and to resume or develop healthy adaptations (33). The perspective is future oriented; troubles should be ameliorated for a better, happier life. Entitlements may have to be discarded so that one can cope with everyday existence. One must accept that life is hard and often unjust and assume responsibility for one's role.

The forensic evaluator, on the other hand, may be allied with (or else opposed to) that part of the evaluee which seeks concrete redress for injury, exculpation from responsibility, or avoidance of responsibility through a finding of incompetence. The evaluator's approach may emphasize psychopathology, in contrast to the normalizing approach of the psychotherapist. The attention paid to a psychopathological slice of past life, without any hope-giving search for renewal and remediation, may foster a depressive rather than an encouraging outlook.

People often bring legal action in the belief that it will be therapeutic and empowering. Sometimes it is, but it can also be traumatic. Moreover, the sense of entitlement fostered by an unremitting quest for justice tends to harden characterological defenses, thereby making constructive change more elusive. In such cases, litigation may be said to bring about a developmental arrest or regression antithetical to therapeutic growth. Given such risks, the proper role of a treating therapist is not to encourage a lawsuit or to be the patient's legal advocate. Rather, it is to assist the patient in deciding whether or not to bring suit and to provide support in going through the legal process, if that be the decision. The therapist ought to stand at the same distance from the lawsuit as from any other significant event in the patient's life.

Empathy

Empathy, when used as a therapeutic technique, enables the patient to feel understood and facilitates the achievement of insight. Contrary to stereotype, empathy is not necessarily absent from the forensic evaluation, since a skilled evaluator creates an atmosphere in which the evaluee feels free to speak within the limits set by the absence of confidentiality (28). However, even the legitimate use of empathy can lead to a quasi-therapeutic interaction that ultimately leaves the evaluee feeling betrayed by the evaluator's report (34).

The clinician's habit of empathic identification, if not balanced by objectivity, can bias a forensic evaluation even in the absence of a treating relationship. Stone (35) argues, therefore, that forensic evaluators must be prepared to withdraw from the forensic role when a forensic evaluation turns into a therapeutic encounter. How much greater, then, the likelihood of bias in the case of a treating therapist, whose mission of promoting patient welfare calls for deliberate identification (at the risk of overidentification) with the patient.

Neutrality

Therapeutic neutrality (36)—that posture of helping the patient listen to himself or herself without critical judgment, and fostering self-knowledge through the emergence of hidden feelings and attitudes—is undermined when the clinician acts as a forensic consultant to the patient or attorney; judgmental assessments are inevitable in that role, and serious real-world consequences may turn on every utterance of the patient. The crucial therapeutic posture of expectant listener, to whom anything may be said without consequence or penalty, is compromised. Free access to the patient's inner world is impeded as each disclosure is weighed, not just against "What will she [or he] think of me?" but also "How will what I say affect the outcome of my case?" Neutrality vanishes as the therapist assumes the consultant's role of advocacy for an opinion supporting the patient's cause (37), a role assumed in the U.S. Supreme Court's *Ake* decision (38). Both patient's and therapist's rescue fantasies are activated, with their potential for idealization of the therapist and regression and infantilization of the patient. Patient autonomy and responsibility correspondingly diminish.

Anonymity

The anonymity of the psychotherapist, which aids in the development and interpretation of transference (39) and the mobilization of clinically useful projections onto the therapist, is clearly compromised by the legal process. Such anonymity, which may be a key to the residual attitudes of the patient's relationships with important figures in his or her past, is contaminated when the therapist steps out of the transference relationship and into the patient's present, external world. The patient who sees his or her therapist on the witness stand may have strong reactions, not only to the testimony itself, but to whatever is exposed about the clinician's professional background, character, or personal history. Problems also arise if the patient sees the therapist embarrassed by a vigorous and effective cross-examination. Will confidence and trust not be diminished by fears of the therapist's vulnerability?

ASSESSMENTS

Further incompatibilities between the roles of treater and expert become apparent when we consider how each obtains, evaluates, and interprets information. A clinical assessment is not the same as a forensic assessment.

holding the fairness of the justice system. Nonetheless, that way of doing good is not part of the *treating* physician's role. A person who suffers harm from adverse or painful testimony should not suffer the additional pain of having that testimony emerge from a doctor-patient relationship.

Reimbursement

Another ethical issue arises when the psychotherapist goes to court. If a prognosis is offered that a patient will require long-term treatment, the therapist, as treater, stands to benefit directly from this statement (29). This financial stake in the outcome may destroy the credibility of the therapist's testimony. It places the therapist in the position of testifying for a built-in contingency fee, which is unethical for forensic psychiatrists (18) and forensic psychologists (21)—and, by extension, for treaters who testify.

Agency

Clear disclosure of whose "agent" one serves as—i.e., whom one is working for—is required in both the clinical and forensic arenas. Barring an emergency, including danger to others or "public peril," a therapist works only for the patient. Such an "agency statement" is usually implicit in a contract between psychiatrist and patient for individual psychotherapy (33). In the forensic context, however, the combined therapist/expert witness must serve two masters, the patient/examinee and the law. When the therapist thus blurs his or her role, the patient's claim to sole allegiance is compromised.

The biasing effect of agency on forensic evaluations, a matter of concern to forensic specialists (48), is called forensic identification—a process by which evaluators unintentionally adopt the viewpoint of the attorneys who have retained them (49). If agency biases forensic opinion, agency conflict, or double agency, must influence both the evaluator (therapist) and evaluee (patient).

Confidentiality

The question of confidentiality goes hand in hand with that of agency. Who is listening? What will be revealed and where? The privacy of the consulting room, protected by law, is essential to frank communication during which a patient suspends self-judgment. In its *Jaffee v. Redmond* decision in 1996 (50), the U.S. Supreme Court gave unequivocal protection to the confidentiality of the psychotherapeutic relationship. Given the Court's reaffirmation of the primacy of therapeutic confidentiality, over and above other vital interests of society, clinicians would be unwise to compromise this right by carelessly crossing the boundary into the forensic arena.

A patient who puts his or her mental condition at legal issue and thereby waives privilege loses that privacy. Although the patient may consent to breaching privacy for the purpose of litigation, the prior confidential relationship may be incapable of being restored after the litigation is over. Moreover, the patient's consent to reveal treatment records may not constitute informed consent to full disclosure in court to family members, the press, or curious bystanders (46). A warning that the adversarial discovery process may reveal closely held personal details may not address the full extent of the exposure that occurs and its emotional consequences.

These hazards of litigation are present whether or not the therapist actually testifies. If the therapist agrees to act as a forensic evaluator, the hazards intensify. While a treating therapist may sometimes successfully appeal to exclude intimate material because of its irrelevance, the forensic evaluator is less likely to be able to withhold anything learned in the course of an evaluation.

RISKS FOR THE CLINICIAN WHO ACTS IN A DUAL ROLE

At a time when forensic experts have been held liable for negligence in evaluation (51), the therapist who attempts to combine the roles of treating clinician and forensic evaluator embarks on especially treacherous waters. Even a clinician who testifies as a fact witness may find this seemingly unambiguous role compromised (50). In court, the fact witness may face pressure to give an expert opinion without receiving an expert witness's fee (52). Worse, a therapist whose factual testimony displeases the patient may later be charged with negligence for having failed to carry out the investigatory tasks of a forensic expert (53).

These problems are best avoided by offering the patient's treatment records in lieu of testimony. The clinician who does testify as a fact witness should rigorously maintain role boundaries by declining to perform the functions of an expert witness, such as reviewing the reports or depositions of other witnesses. A therapist who is asked to give expert testimony about a patient can respond to an attorney's request, a subpoena, or (at last resort) courtroom questioning with a disclaimer such as this: "Having observed the patient only from the vantage point of a treating clinician, I have no objective basis for rendering an expert opinion, with a reasonable degree of medical certainty, on a legal as opposed to a clinical question."

CAVEATS

1. *Ruling out this form of dual relationship is not meant to limit the expert role to a small group of specialists.* Any professional can serve as an expert witness within the limits of his or her expertise. A psychiatrist without specialized credentials in forensic psychiatry can still perform evaluations and testify as an expert in psychiatry.

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Office of the High Commissioner for Human Rights

Universal Declaration of Human Rights

English Version

Source: United Nations Department of Public Information

Universal Declaration of Human Rights

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly,

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1

PROFILE

Native Name

English

Total Speakers

322,000,000 (1995)

Usage by Country

Europe -
Official Language: Gibraltar, Ireland Malta, United Kingdom

Asia -
Official Language: India, Pakistan, Philippines, Singapore

Africa -
Official Language: Botswana, Cameroon, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mauritius, Namibia, Nigeria, Sierra Leone, Sou Africa, Swaziland, Tanzania, Uganda Zambia

Central and South America -
Official Language: Anguilla, Antigua Barbuda, Bahamas, Barbados, Beliz Bermuda, Br. Virgin Isl.s, Dominica, Falklands, Grenada, Guyana, Jamai Montserrat, Puerto Rico, St. Kitts & Nevis, St. Lucia, St. Vincent, Trinida & Tobago, Turks & Caicos Islands, U Virgin Islands

North America -
Official Language: Canada, USA

Oceania -
Official Language: American Samoa, Australia, Belau, Cook Islands, Fiji, Guam, Kiribati, Marshall Islands, Micronesia, Nauru, New Zealand, Niue, Norfolk Islands, Northern Mariannas, Papua New Guinea, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Western Samoa.

Background

It belongs to the Indo-European family, Germanic group, West Germanic subgroup and is the offici language of over 1.7 billion people. Home speakers are over 330 million As regards the evolution of the Engl language, three main phases can be distinguished. From the 6th and 5th centuries B.C., the Celtics are believ to have lived in the place where we now call Britain. Britain first appear in the historical records as Julius Caesar campaigned there in 55-54 B.C. Britain was conquered in 43 A.I and remained under the Roman

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.
2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Send e-mail with comments and suggestions to:
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Geneva Convention relative to the Treatment of Prisoners of War

Adopted on 12 August 1949 by the Diplomatic Conference for the Establishment of International Conventions for the Protection of Victims of War, held in Geneva from 21 April to 12 August, 1949

***entry into force* 21 October 1950**

PART I

GENERAL PROVISIONS

Article 1

The High Contracting Parties undertake to respect and to ensure respect for the present Convention in all circumstances.

Article 2

In addition to the provisions which shall be implemented in peace time, the present Convention shall apply to all cases of declared war or of any other armed conflict which may arise between two or more of the High Contracting Parties, even if the state of war is not recognized by one of them.

The Convention shall also apply to all cases of partial or total occupation of the territory of a High Contracting Party, even if the said occupation meets with no armed resistance.

Although one of the Powers in conflict may not be a party to the present Convention, the Powers who are parties thereto shall remain bound by it in their mutual relations. They shall furthermore be bound by the Convention in relation to the said Power, if the latter accepts and applies the provisions thereof.

Article 3

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end the following acts are and shall remain prohibited at any time and in any place

civilian members of military aircraft crews, war correspondents, supply contractors, members of labour units or of services responsible for the welfare of the armed forces, provided that they have received authorization from the armed forces which they accompany, who shall provide them for that purpose with an identity card similar to the annexed model.

5. Members of crews, including masters, pilots and apprentices, of the merchant marine and the crews of civil aircraft of the Parties to the conflict, who do not benefit by more favourable treatment under any other provisions of international law.

6. Inhabitants of a non-occupied territory, who on the approach of the enemy spontaneously take up arms to resist the invading forces, without having had time to form themselves into regular armed units, provided they carry arms openly and respect the laws and customs of war.

B. The following shall likewise be treated as prisoners of war under the present Convention:

1. Persons belonging, or having belonged, to the armed forces of the occupied country, if the occupying Power considers it necessary by reason of such allegiance to intern them, even though it has originally liberated them while hostilities were going on outside the territory it occupies, in particular where such persons have made an unsuccessful attempt to rejoin the armed forces to which they belong and which are engaged in combat, or where they fail to comply with a summons made to them with a view to internment.

2. The persons belonging to one of the categories enumerated in the present Article, who have been received by neutral or non-belligerent Powers on their territory and whom these Powers are required to intern under international law, without prejudice to any more favourable treatment which these Powers may choose to give and with the exception of Articles 8, 10, 15, 30, fifth paragraph, 58-67, 92, 126 and, where diplomatic relations exist between the Parties to the conflict and the neutral or non-belligerent Power concerned, those Articles concerning the Protecting Power. Where such diplomatic relations exist, the Parties to a conflict on whom these persons depend shall be allowed to perform towards them the functions of a Protecting Power as provided in the present Convention, without prejudice to the functions which these Parties normally exercise in conformity with diplomatic and consular usage and treaties.

C. This Article shall in no way affect the status of medical personnel and chaplains as provided for in Article 33 of the present Convention.

Article 5

The present Convention shall apply to the persons referred to in Article 4 from the time they fall into the power of the enemy and until their final release and repatriation.

Should any doubt arise as to whether persons, having committed a belligerent act and having fallen into the hands of the enemy, belong to any of the categories enumerated in Article 4, such persons shall enjoy the protection of the present Convention until such time as their status has been determined by a competent tribunal.

Article 6

In addition to the agreements expressly provided for in Articles 10, 23, 28, 33, 60, 65, 66, 67,

If protection cannot be arranged accordingly, the Detaining Power shall request or shall accept, subject to the provisions of this Article, the offer of the services of a humanitarian organization, such as the International Committee of the Red Cross, to assume the humanitarian functions performed by Protecting Powers under the present Convention.

Any neutral Power or any organization invited by the Power concerned or offering itself for these purposes, shall be required to act with a sense of responsibility towards the Party to the conflict on which persons protected by the present Convention depend, and shall be required to furnish sufficient assurances that it is in a position to undertake the appropriate functions and to discharge them impartially.

No derogation from the preceding provisions shall be made by special agreements between Powers one of which is restricted, even temporarily, in its freedom to negotiate with the other Power or its allies by reason of military events, more particularly where the whole, or a substantial part, of the territory of the said Power is occupied.

Whenever in the present Convention mention is made of a Protecting Power, such mention applies to substitute organizations in the sense of the present Article.

Article 11

In cases where they deem it advisable in the interest of protected persons, particularly in cases of disagreement between the Parties to the conflict as to the application or interpretation of the provisions of the present Convention, the Protecting Powers shall lend their good offices with a view to settling the disagreement.

For this purpose, each of the Protecting Powers may, either at the invitation of one Party or on its own initiative, propose to the Parties to the conflict a meeting of their representatives, and in particular of the authorities responsible for prisoners of war, possibly on neutral territory suitably chosen. The Parties to the conflict shall be bound to give effect to the proposals made to them for this purpose. The Protecting Powers may, if necessary, propose for approval by the Parties to the conflict a person belonging to a neutral Power, or delegated by the International Committee of the Red Cross, who shall be invited to take part in such a meeting.

PART II

GENERAL PROTECTION OF PRISONERS OF WAR

Article 12

Prisoners of war are in the hands of the enemy Power, but not of the individuals or military units who have captured them. Irrespective of the individual responsibilities that may exist, the Detaining Power is responsible for the treatment given them.

Prisoners of war may only be transferred by the Detaining Power to a Power which is a party to the Convention and after the Detaining Power has satisfied itself of the willingness and ability of such transferee Power to apply the Convention. When prisoners of war are transferred under such circumstances, responsibility for the application of the Convention rests on the Power accepting them while they are in its custody.

Every prisoner of war, when questioned on the subject, is bound to give only his surname, first names and rank, date of birth, and army, regimental, personal or serial number, or failing this, equivalent information. If he wilfully infringes this rule, he may render himself liable to a restriction of the privileges accorded to his rank or status.

Each Party to a conflict is required to furnish the persons under its jurisdiction who are liable to become prisoners of war, with an identity card showing the owner's surname, first names, rank, army, regimental, personal or serial number or equivalent information, and date of birth. The identity card may, furthermore, bear the signature or the fingerprints, or both, of the owner, and may bear, as well, any other information the Party to the conflict may wish to add concerning persons belonging to its armed forces. As far as possible the card shall measure 6.5 x 10 cm. and shall be issued in duplicate. The identity card shall be shown by the prisoner of war upon demand, but may in no case be taken away from him.

No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind.

Prisoners of war who, owing to their physical or mental condition, are unable to state their identity, shall be handed over to the medical service. The identity of such prisoners shall be established by all possible means, subject to the provisions of the preceding paragraph.

The questioning of prisoners of war shall be carried out in a language which they understand.

Article 18

All effects and articles of personal use, except arms, horses, military equipment and military documents shall remain in the possession of prisoners of war, likewise their metal helmets and gas masks and like articles issued for personal protection. Effects and articles used for their clothing or feeding shall likewise remain in their possession, even if such effects and articles belong to their regulation military equipment.

At no time should prisoners of war be without identity documents. The Detaining Power shall supply such documents to prisoners of war who possess none.

Badges of rank and nationality, decorations and articles having above all a personal or sentimental value may not be taken from prisoners of war.

Sums of money carried by prisoners of war may not be taken away from them except by order of an officer, and after the amount and particulars of the owner have been recorded in a special register and an itemized receipt has been given, legibly inscribed with the name, rank and unit of the person issuing the said receipt. Sums in the currency of the Detaining Power, or which are changed into such currency at the prisoner's request, shall be placed to the credit of the prisoner's account as provided in Article 64.

The Detaining Power may withdraw articles of value from prisoners of war only for reasons of security; when such articles are withdrawn, the procedure laid down for sums of money impounded shall apply.

prisoner of war shall be compelled to accept liberty on parole or promise.

Upon the outbreak of hostilities, each Party to the conflict shall notify the adverse Party of the laws and regulations allowing or forbidding its own nationals to accept liberty on parole or promise. Prisoners of war who are paroled or who have given their promise in conformity with the laws and regulations so notified, are bound on their personal honour scrupulously to fulfil, both towards the Power on which they depend and towards the Power which has captured them, the engagements of their paroles or promises. In such cases, the Power on which they depend is bound neither to require nor to accept from them any service incompatible with the parole or promise given.

Article 22

Prisoners of war may be interned only in premises located on land and affording every guarantee of hygiene and healthfulness. Except in particular cases which are justified by the interest of the prisoners themselves, they shall not be interned in penitentiaries.

Prisoners of war interned in unhealthy areas, or where the climate is injurious for them, shall be removed as soon as possible to a more favourable climate.

The Detaining Power shall assemble prisoners of war in camps or camp compounds according to their nationality, language and customs, provided that such prisoners shall not be separated from prisoners of war belonging to the armed forces with which they were serving at the time of their capture, except with their consent.

Article 23

No prisoner of war may at any time be sent to or detained in areas where he may be exposed to the fire of the combat zone, nor may his presence be used to render certain points or areas immune from military operations.

Prisoners of war shall have shelters against air bombardment and other hazards of war, to the same extent as the local civilian population. With the exception of those engaged in the protection of their quarters against the aforesaid hazards, they may enter such shelters as soon as possible after the giving of the alarm. Any other protective measure taken in favour of the population shall also apply to them.

Detaining Powers shall give the Powers concerned, through the intermediary of the Protecting Powers, all useful information regarding the geographical location of prisoner of war camps.

Whenever military considerations permit, prisoner of war camps shall be indicated in the day-time by the letters PW or PG, placed so as to be clearly visible from the air. The Powers concerned may, however, agree upon any other system of marking. Only prisoner of war camps shall be marked as such.

Article 24

Transit or screening camps of a permanent kind shall be fitted out under conditions similar to those described in the present Section, and the prisoners therein shall have the same treatment as in other camps.

The regular replacement and repair of the above articles shall be assured by the Detaining Power. In addition, prisoners of war who work shall receive appropriate clothing, wherever the nature of the work demands.

Article 28

Canteens shall be installed in all camps, where prisoners of war may procure foodstuffs, soap and tobacco and ordinary articles in daily use. The tariff shall never be in excess of local market prices. The profits made by camp canteens shall be used for the benefit of the prisoners; a special fund shall be created for this purpose. The prisoners' representative shall have the right to collaborate in the management of the canteen and of this fund.

When a camp is closed down, the credit balance of the special fund shall be handed to an international welfare organization, to be employed for the benefit of prisoners of war of the same nationality as those who have contributed to the fund. In case of a general repatriation, such profits shall be kept by the Detaining Power, subject to any agreement to the contrary between the Powers concerned.

Chapter III

HYGIENE AND MEDICAL ATTENTION

Article 29

The Detaining Power shall be bound to take all sanitary measures necessary to ensure the cleanliness and healthfulness of camps and to prevent epidemics.

Prisoners of war shall have for their use, day and night, conveniences which conform to the rules of hygiene and are maintained in a constant state of cleanliness. In any camps in which women prisoners of war are accommodated, separate conveniences shall be provided for them.

Also, apart from the baths and showers with which the camps shall be furnished, prisoners of war shall be provided with sufficient water and soap for their personal toilet and for washing their personal laundry; the necessary installations, facilities and time shall be granted them for that purpose.

Article 30

Every camp shall have an adequate infirmary where prisoners of war may have the attention they require, as well as appropriate diet. Isolation wards shall, if necessary, be set aside for cases of contagious or mental disease.

Prisoners of war suffering from serious disease, or whose condition necessitates special treatment, a surgical operation or hospital care, must be admitted to any military or civilian medical unit where such treatment can be given, even if their repatriation is contemplated in the near future. Special facilities shall be afforded for the care to be given to the disabled, in particular to the blind, and for their rehabilitation, pending repatriation.

Prisoners of war shall have the attention, preferably, of medical personnel of the Power on

place at their disposal the necessary means of transport.

(b) The senior medical officer in each camp shall be responsible to the camp military authorities for everything connected with the activities of retained medical personnel. For this purpose, Parties to the conflict shall agree at the outbreak of hostilities on the subject of the corresponding ranks of the medical personnel, including that of societies mentioned in Article 26 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949. This senior medical officer, as well as chaplains, shall have the right to deal with the competent authorities of the camp on all questions relating to their duties. Such authorities shall afford them all necessary facilities for correspondence relating to these questions.

(c) Although they shall be subject to the internal discipline of the camp in which they are retained, such personnel may not be compelled to carry out any work other than that concerned with their medical or religious duties.

During hostilities, the Parties to the conflict shall agree concerning the possible relief of retained personnel and shall settle the procedure to be followed.

None of the preceding provisions shall relieve the Detaining Power of its obligations with regard to prisoners of war from the medical or spiritual point of view.

Chapter V

RELIGIOUS, INTELLECTUAL AND PHYSICAL ACTIVITIES

Article 34

Prisoners of war shall enjoy complete latitude in the exercise of their religious duties, including attendance at the service of their faith, on condition that they comply with the disciplinary routine prescribed by the military authorities.

Adequate premises shall be provided where religious services may be held.

Article 35

Chaplains who fall into the hands of the enemy Power and who remain or are retained with a view to assisting prisoners of war, shall be allowed to minister to them and to exercise freely their ministry amongst prisoners of war of the same religion, in accordance with their religious conscience. They shall be allocated among the various camps and labour detachments containing prisoners of war belonging to the same forces, speaking the same language or practising the same religion. They shall enjoy the necessary facilities, including the means of transport provided for in Article 33, for visiting the prisoners of war outside their camp. They shall be free to correspond, subject to censorship, on matters concerning their religious duties with the ecclesiastical authorities in the country of detention and with international religious organizations. Letters and cards which they may send for this purpose shall be in addition to the quota provided for in Article 71.

Article 36

Article 41

In every camp the text of the present Convention and its Annexes and the contents of any special agreement provided for in Article 6, shall be posted, in the prisoners' own language, at places where all may read them. Copies shall be supplied, on request, to the prisoners who cannot have access to the copy which has been posted.

Regulations, orders, notices and publications of every kind relating to the conduct of prisoners of war shall be issued to them in a language which they understand. Such regulations, orders and publications shall be posted in the manner described above and copies shall be handed to the prisoners' representative. Every order and command addressed to prisoners of war individually must likewise be given in a language which they understand.

Article 42

The use of weapons against prisoners of war, especially against those who are escaping or attempting to escape, shall constitute an extreme measure, which shall always be preceded by warnings appropriate to the circumstances.

Chapter VII

RANK OF PRISONERS OF WAR

Article 43

Upon the outbreak of hostilities, the Parties to the conflict shall communicate to one another the titles and ranks of all the persons mentioned in Article 4 of the present Convention, in order to ensure equality of treatment between prisoners of equivalent rank. Titles and ranks which are subsequently created shall form the subject of similar communications.

The Detaining Power shall recognize promotions in rank which have been accorded to prisoners of war and which have been duly notified by the Power on which these prisoners depend.

Article 44

Officers and prisoners of equivalent status shall be treated with the regard due to their rank and age.

In order to ensure service in officers' camps, other ranks of the same armed forces who, as far as possible, speak the same language, shall be assigned in sufficient numbers, account being taken of the rank of officers and prisoners of equivalent status. Such orderlies shall not be required to perform any other work.

Supervision of the mess by the officers themselves shall be facilitated in every way.

Article 45

Prisoners of war other than officers and prisoners of equivalent status shall be treated with the regard due to their rank and age.

SECTION III

LABOUR OF PRISONERS OF WAR

Article 49

The Detaining Power may utilize the labour of prisoners of war who are physically fit, taking into account their age, sex, rank and physical aptitude, and with a view particularly to maintaining them in a good state of physical and mental health.

Non-commissioned officers who are prisoners of war shall only be required to do supervisory work. Those not so required may ask for other suitable work which shall, so far as possible, be found for them.

If officers or persons of equivalent status ask for suitable work, it shall be found for them, so far as possible, but they may in no circumstances be compelled to work.

Article 50

Besides work connected with camp administration, installation or maintenance, prisoners of war may be compelled to do only such work as is included in the following classes:

(a) Agriculture;

(b) Industries connected with the production or the extraction of raw materials, and manufacturing industries, with the exception of metallurgical, machinery and chemical industries; public works and building operations which have no military character or purpose;

(c) Transport and handling of stores which are not military in character or purpose;

(d) Commercial business, and arts and crafts;

(e) Domestic service;

(f) Public utility services having no military character or purpose.

Should the above provisions be infringed, prisoners of war shall be allowed to exercise their right of complaint, in conformity with Article 78.

Article 51

Prisoners of war must be granted suitable working conditions, especially as regards accommodation, food, clothing and equipment; such conditions shall not be inferior to those enjoyed by nationals of the Detaining Power employed in similar work; account shall also be taken of climatic conditions.

The Detaining Power, in utilizing the labour of prisoners of war, shall ensure that in areas in which prisoners are employed, the national legislation concerning the protection of labour, and, more particularly, the regulations for the safety of workers, are duly applied.

If any prisoner of war considers himself incapable of working, he shall be permitted to appear before the medical authorities of his camp. Physicians or surgeons may recommend that the prisoners who are, in their opinion, unfit for work, be exempted therefrom.

Article 56

The organization and administration of labour detachments shall be similar to those of prisoner of war camps.

Every labour detachment shall remain under the control of and administratively part of a prisoner of war camp. The military authorities and the commander of the said camp shall be responsible, under the direction of their government, for the observance of the provisions of the present Convention in labour detachments.

The camp commander shall keep an up-to-date record of the labour detachments dependent on his camp, and shall communicate it to the delegates of the Protecting Power, of the International Committee of the Red Cross, or of other agencies giving relief to prisoners of war, who may visit the camp.

Article 57

The treatment of prisoners of war who work for private persons, even if the latter are responsible for guarding and protecting them, shall not be inferior to that which is provided for by the present Convention. The Detaining Power, the military authorities and the commander of the camp to which such prisoners belong shall be entirely responsible for the maintenance, care, treatment, and payment of the working pay of such prisoners of war.

Such prisoners of war shall have the right to remain in communication with the prisoners' representatives in the camps on which they depend.

SECTION IV

FINANCIAL RESOURCES OF PRISONERS OF WAR

Article 58

Upon the outbreak of hostilities, and pending an arrangement on this matter with the Protecting Power, the Detaining Power may determine the maximum amount of money in cash or in any similar form, that prisoners may have in their possession. Any amount in excess, which was properly in their possession and which has been taken or withheld from them, shall be placed to their account, together with any monies deposited by them, and shall not be converted into any other currency without their consent.

If prisoners of war are permitted to purchase services or commodities outside the camp against payment in cash, such payments shall be made by the prisoner himself or by the camp administration who will charge them to the accounts of the prisoners concerned. The Detaining

Article 61

The Detaining Power shall accept for distribution as supplementary pay to prisoners of war sums which the Power on which the prisoners depend may forward to them, on condition that the sums to be paid shall be the same for each prisoner of the same category, shall be payable to all prisoners of that category depending on that Power, and shall be placed in their separate accounts, at the earliest opportunity, in accordance with the provisions of Article 64. Such supplementary pay shall not relieve the Detaining Power of any obligation under this Convention.

Article 62

Prisoners of war shall be paid a fair working rate of pay by the detaining authorities direct. The rate shall be fixed by the said authorities, but shall at no time be less than one-fourth of one Swiss franc for a full working day. The Detaining Power shall inform prisoners of war, as well as the Power on which they depend, through the intermediary of the Protecting Power, of the rate of daily working pay that it has fixed.

Working pay shall likewise be paid by the detaining authorities to prisoners of war permanently detailed to duties or to a skilled or semi-skilled occupation in connection with the administration, installation or maintenance of camps, and to the prisoners who are required to carry out spiritual or medical duties on behalf of their comrades.

The working pay of the prisoners' representative, of his advisers, if any, and of his assistants, shall be paid out of the fund maintained by canteen profits. The scale of this working pay shall be fixed by the prisoners' representative and approved by the camp commander. If there is no such fund, the detaining authorities shall pay these prisoners a fair working rate of pay.

Article 63

Prisoners of war shall be permitted to receive remittances of money addressed to them individually or collectively.

Every prisoner of war shall have at his disposal the credit balance of his account as provided for in the following Article, within the limits fixed by the Detaining Power, which shall make such payments as are requested. Subject to financial or monetary restrictions which the Detaining Power regards as essential, prisoners of war may also have payments made abroad. In this case payments addressed by prisoners of war to dependants shall be given priority.

In any event, and subject to the consent of the Power on which they depend, prisoners may have payments made in their own country, as follows: the Detaining Power shall send to the aforesaid Power through the Protecting Power a notification giving all the necessary particulars concerning the prisoners of war, the beneficiaries of the payments, and the amount of the sums to be paid, expressed in the Detaining Power's currency. The said notification shall be signed by the prisoners and countersigned by the camp commander. The Detaining Power shall debit the prisoners' account by a corresponding amount; the sums thus debited shall be placed by it to the credit of the Power on which the prisoners depend.

To apply the foregoing provisions, the Detaining Power may usefully consult the Model

Advances of pay, issued to prisoners of war in conformity with Article 60, shall be considered as made on behalf of the Power on which they depend. Such advances of pay, as well as all payments made by the said Power under Article 63, third paragraph, and Article 68, shall form the subject of arrangements between the Powers concerned, at the close of hostilities.

Article 68

Any claim by a prisoner of war for compensation in respect of any injury or other disability arising out of work shall be referred to the Power on which he depends, through the Protecting Power. In accordance with Article 54, the Detaining Power will, in all cases, provide the prisoner of war concerned with a statement showing the nature of the injury or disability, the circumstances in which it arose and particulars of medical or hospital treatment given for it. This statement will be signed by a responsible officer of the Detaining Power and the medical particulars certified by a medical officer.

Any claim by a prisoner of war for compensation in respect of personal effects, monies or valuables impounded by the Detaining Power under Article 18 and not forthcoming on his repatriation, or in respect of loss alleged to be due to the fault of the Detaining Power or any of its servants, shall likewise be referred to the Power on which he depends. Nevertheless, any such personal effects required for use by the prisoners of war whilst in captivity shall be replaced at the expense of the Detaining Power. The Detaining Power will, in all cases, provide the prisoner of war with a statement, signed by a responsible officer, showing all available information regarding the reasons why such effects, monies or valuables have not been restored to him. A copy of this statement will be forwarded to the Power on which he depends through the Central Prisoners of War Agency provided for in Article 123.

SECTION V

RELATIONS OF PRISONERS OF WAR WITH THE EXTERIOR

Article 69

Immediately upon prisoners of war falling into its power, the Detaining Power shall inform them and the Powers on which they depend, through the Protecting Power, of the measures taken to carry out the provisions of the present Section. They shall likewise inform the parties concerned of any subsequent modifications of such measures.

Article 70

Immediately upon capture, or not more than one week after arrival at a camp, even if it is a transit camp, likewise in case of sickness or transfer to hospital or another camp, every prisoner of war shall be enabled to write direct to his family, on the one hand, and to the Central Prisoners of War Agency provided for in Article 123, on the other hand, a card similar, if possible, to the model annexed to the present Convention, informing his relatives of his capture, address and state of health. The said cards shall be forwarded as rapidly as possible and may not be delayed in any manner.

Article 71

Prisoners of war shall be allowed to send and receive letters and cards. If the Detaining Power

collective shipments, which are annexed to the present Convention, shall be applied.

The special agreements referred to above shall in no case restrict the right of prisoners' representatives to take possession of collective relief shipments intended for prisoners of war, to proceed to their distribution or to dispose of them in the interest of the prisoners.

Nor shall such agreements restrict the right of representatives of the Protecting Power, the International Committee of the Red Cross or any other organization giving assistance to prisoners of war and responsible for the forwarding of collective shipments, to supervise their distribution to the recipients.

Article 74

All relief shipments for prisoners of war shall be exempt from import, customs and other dues.

Correspondence, relief shipments and authorized remittances of money addressed to prisoners of war or despatched by them through the post office, either direct or through the Information Bureaux provided for in Article 122 and the Central Prisoners of War Agency provided for in Article 123, shall be exempt from any postal dues, both in the countries of origin and destination, and in intermediate countries.

If relief shipments intended for prisoners of war cannot be sent through the post office by reason of weight or for any other cause, the cost of transportation shall be borne by the Detaining Power in all the territories under its control. The other Powers party to the Convention shall bear the cost of transport in their respective territories.

In the absence of special agreements between the Parties concerned, the costs connected with transport of such shipments, other than costs covered by the above exemption, shall be charged to the senders.

The High Contracting Parties shall endeavour to reduce, so far as possible, the rates charged for telegrams sent by prisoners of war, or addressed to them.

Article 75

Should military operations prevent the Powers concerned from fulfilling their obligation to assure the transport of the shipments referred to in Articles 70, 71, 72 and 77, the Protecting Powers concerned, the International Committee of the Red Cross or any other organization duly approved by the Parties to the conflict may undertake to ensure the conveyance of such shipments by suitable means (railway wagons, motor vehicles, vessels or aircraft, etc.). For this purpose, the High Contracting Parties shall endeavour to supply them with such transport and to allow its circulation, especially by granting the necessary safe-conducts.

Such transport may also be used to convey:

(a) Correspondence, lists and reports exchanged between the Central Information Agency referred to in Article 123 and the National Bureaux referred to in Article 122;

(b) Correspondence and reports relating to prisoners of war which the Protecting Powers, the International Committee of the Red Cross or any other body assisting the prisoners, exchange

They shall also have the unrestricted right to apply to the representatives of the Protecting Powers either through their prisoners' representative or, if they consider it necessary, direct, in order to draw their attention to any points on which they may have complaints to make regarding their conditions of captivity.

These requests and complaints shall not be limited nor considered to be a part of the correspondence quota referred to in Article 71. They must be transmitted immediately. Even if they are recognized to be unfounded, they may not give rise to any punishment.

Prisoners' representatives may send periodic reports on the situation in the camps and the needs of the prisoners of war to the representatives of the Protecting Powers.

Chapter II

PRISONER OF WAR REPRESENTATIVES

Article 79

In all places where there are prisoners of war, except in those where there are officers, the prisoners shall freely elect by secret ballot, every six months, and also in case of vacancies, prisoners' representatives entrusted with representing them before the military authorities, the Protecting Powers, the International Committee of the Red Cross and any other organization which may assist them. These prisoners' representatives shall be eligible for re-election.

In camps for officers and persons of equivalent status or in mixed camps, the senior officer among the prisoners of war shall be recognized as the camp prisoners' representative. In camps for officers, he shall be assisted by one or more advisers chosen by the officers; in mixed camps, his assistants shall be chosen from among the prisoners of war who are not officers and shall be elected by them.

Officer prisoners of war of the same nationality shall be stationed in labour camps for prisoners of war, for the purpose of carrying out the camp administration duties for which the prisoners of war are responsible. These officers may be elected as prisoners' representatives under the first paragraph of this Article. In such a case the assistants to the prisoners' representatives shall be chosen from among those prisoners of war who are not officers.

Every representative elected must be approved by the Detaining Power before he has the right to commence his duties. Where the Detaining Power refuses to approve a prisoner of war elected by his fellow prisoners of war, it must inform the Protecting Power of the reason for such refusal.

In all cases the prisoners' representative must have the same nationality, language and customs as the prisoners of war whom he represents. Thus, prisoners of war distributed in different sections of a camp, according to their nationality, language or customs, shall have for each section their own prisoners' representative, in accordance with the foregoing paragraphs.

Article 80

Prisoners' representatives shall further the physical, spiritual and intellectual well-being of prisoners of war.

by a member of the forces of the Detaining Power, such acts shall entail disciplinary punishments only.

Article 83

In deciding whether proceedings in respect of an offence alleged to have been committed by a prisoner of war shall be judicial or disciplinary, the Detaining Power shall ensure that the competent authorities exercise the greatest leniency and adopt, wherever possible, disciplinary rather than judicial measures.

Article 84

A prisoner of war shall be tried only by a military court, unless the existing laws of the Detaining Power expressly permit the civil courts to try a member of the armed forces of the Detaining Power in respect of the particular offence alleged to have been committed by the prisoner of war.

In no circumstances whatever shall a prisoner of war be tried by a court of any kind which does not offer the essential guarantees of independence and impartiality as generally recognized, and, in particular, the procedure of which does not afford the accused the rights and means of defence provided for in Article 105.

Article 85

Prisoners of war prosecuted under the laws of the Detaining Power for acts committed prior to capture shall retain, even if convicted, the benefits of the present Convention.

Article 86

No prisoner of war may be punished more than once for the same act, or on the same charge.

Article 87

Prisoners of war may not be sentenced by the military authorities and courts of the Detaining Power to any penalties except those provided for in respect of members of the armed forces of the said Power who have committed the same acts.

When fixing the penalty, the courts or authorities of the Detaining Power shall take into consideration, to the widest extent possible, the fact that the accused, not being a national of the Detaining Power, is not bound to it by any duty of allegiance, and that he is in its power as the result of circumstances independent of his own will. The said courts or authorities shall be at liberty to reduce the penalty provided for the violation of which the prisoner of war is accused, and shall therefore not be bound to apply the minimum penalty prescribed.

Collective punishment for individual acts, corporal punishments, imprisonment in premises without daylight and, in general, any form of torture or cruelty, are forbidden.

No prisoner of war may be deprived of his rank by the Detaining Power, or prevented from wearing his badges.

The period between the pronouncing of an award of disciplinary punishment and its execution shall not exceed one month.

When a prisoner of war is awarded a further disciplinary punishment, a period of at least three days shall elapse between the execution of any two of the punishments, if the duration of one of these is ten days or more.

Article 91

The escape of a prisoner of war shall be deemed to have succeeded when:

1. He has joined the armed forces of the Power on which he depends, or those of an allied Power;

2. He has left the territory under the control of the Detaining Power, or of an ally of the said Power;

3. He has joined a ship flying the flag of the Power on which he depends, or of an allied Power, in the territorial waters of the Detaining Power, the said ship not being under the control of the last-named Power.

Prisoners of war who have made good their escape in the sense of this Article and who are recaptured, shall not be liable to any punishment in respect of their previous escape.

Article 92

A prisoner of war who attempts to escape and is recaptured before having made good his escape in the sense of Article 91 shall be liable only to a disciplinary punishment in respect of this act, even if it is a repeated offence.

A prisoner of war who is recaptured shall be handed over without delay to the competent military authority.

Article 88, fourth paragraph, notwithstanding, prisoners of war punished as a result of an unsuccessful escape may be subjected to special surveillance. Such surveillance must not affect the state of their health, must be undergone in a prisoner of war camp, and must not entail the suppression of any of the safeguards granted them by the present Convention.

Article 93

Escape or attempt to escape, even if it is a repeated offence, shall not be deemed an aggravating circumstance if the prisoner of war is subjected to trial by judicial proceedings in respect of an offence committed during his escape or attempt to escape.

In conformity with the principle stated in Article 83, offences committed by prisoners of war with the sole intention of facilitating their escape and which do not entail any violence against life or limb, such as offences against public property, theft without intention of self-enrichment, the drawing up or use of false papers, the wearing of civilian clothing, shall occasion disciplinary punishment only.

requirements set forth in Article 25. A prisoner of war undergoing punishment shall be enabled to keep himself in a state of cleanliness, in conformity with Article 29.

Officers and persons of equivalent status shall not be lodged in the same quarters as non-commissioned officers or men.

Women prisoners of war undergoing disciplinary punishment shall be confined in separate quarters from male prisoners of war and shall be under the immediate supervision of women.

Article 98

A prisoner of war undergoing confinement as a disciplinary punishment, shall continue to enjoy the benefits of the provisions of this Convention except in so far as these are necessarily rendered inapplicable by the mere fact that he is confined. In no case may he be deprived of the benefits of the provisions of Articles 78 and 126.

A prisoner of war awarded disciplinary punishment may not be deprived of the prerogatives attached to his rank.

Prisoners of war awarded disciplinary punishment shall be allowed to exercise and to stay in the open air at least two hours daily.

They shall be allowed, on their request, to be present at the daily medical inspections. They shall receive the attention which their state of health requires and, if necessary, shall be removed to the camp infirmary or to a hospital.

They shall have permission to read and write, likewise to send and receive letters. Parcels and remittances of money, however, may be withheld from them until the completion of the punishment; they shall meanwhile be entrusted to the prisoners' representative, who will hand over to the infirmary the perishable goods contained in such parcels.

III. Judicial proceedings

Article 99

No prisoner of war may be tried or sentenced for an act which is not forbidden by the law of the Detaining Power or by international law, in force at the time the said act was committed.

No moral or physical coercion may be exerted on a prisoner of war in order to induce him to admit himself guilty of the act of which he is accused.

No prisoner of war may be convicted without having had an opportunity to present his defence and the assistance of a qualified advocate or counsel.

Article 100

Prisoners of war and the Protecting Powers shall be informed as soon as possible of the offences which are punishable by the death sentence under the laws of the Detaining Power.

2. Place of internment or confinement;

3. Specification of the charge or charges on which the prisoner of war is to be arraigned, giving the legal provisions applicable;

4 . Designation of the court which will try the case, likewise the date and place fixed for the opening of the trial.

The same communication shall be made by the Detaining Power to the prisoners' representative.

If no evidence is submitted, at the opening of a trial, that the notification referred to above was received by the Protecting Power, by the prisoner of war and by the prisoners' representative concerned, at least three weeks before the opening of the trial, then the latter cannot take place and must be adjourned.

Article 105

The prisoner of war shall be entitled to assistance by one of his prisoner comrades, to defence by a qualified advocate or counsel of his own choice, to the calling of witnesses and, if he deems necessary, to the services of a competent interpreter. He shall be advised of these rights by the Detaining Power in due time before the trial.

Failing a choice by the prisoner of war, the Protecting Power shall find him an advocate or counsel, and shall have at least one week at its disposal for the purpose. The Detaining Power shall deliver to the said Power, on request, a list of persons qualified to present the defence. Failing a choice of an advocate or counsel by the prisoner of war or the Protecting Power, the Detaining Power shall appoint a competent advocate or counsel to conduct the defence.

The advocate or counsel conducting the defence on behalf of the prisoner of war shall have at his disposal a period of two weeks at least before the opening of the trial, as well as the necessary facilities to prepare the defence of the accused. He may, in particular, freely visit the accused and interview him in private. He may also confer with any witnesses for the defence, including prisoners of war. He shall have the benefit of these facilities until the term of appeal or petition has expired.

Particulars of the charge or charges on which the prisoner of war is to be arraigned, as well as the documents which are generally communicated to the accused by virtue of the laws in force in the armed forces of the Detaining Power, shall be communicated to the accused prisoner of war in a language which he understands, and in good time before the opening of the trial. The same communication in the same circumstances shall be made to the advocate or counsel conducting the defence on behalf of the prisoner of war.

The representatives of the Protecting Power shall be entitled to attend the trial of the case, unless, exceptionally, this is held in camera in the interest of State security. In such a case the Detaining Power shall advise the Protecting Power accordingly.

Article 106

Every prisoner of war shall have, in the same manner as the members of the armed forces of

SECTION I

DIRECT REPATRIATION AND ACCOMMODATION IN NEUTRAL COUNTRIES

Article 109

Subject to the provisions of the third paragraph of this Article, Parties to the conflict are bound to send back to their own country, regardless of number or rank, seriously wounded and seriously sick prisoners of war, after having cared for them until they are fit to travel, in accordance with the first paragraph of the following Article.

Throughout the duration of hostilities, Parties to the conflict shall endeavour, with the cooperation of the neutral Powers concerned, to make arrangements for the accommodation in neutral countries of the sick and wounded prisoners of war referred to in the second paragraph of the following Article. They may, in addition, conclude agreements with a view to the direct repatriation or internment in a neutral country of able-bodied prisoners of war who have undergone a long period of captivity.

No sick or injured prisoner of war who is eligible for repatriation under the first paragraph of this Article, may be repatriated against his will during hostilities.

Article 110

The following shall be repatriated direct:

1. Incurably wounded and sick whose mental or physical fitness seems to have been gravely diminished.

2. Wounded and sick who, according to medical opinion, are not likely to recover within one year, whose condition requires treatment and whose mental or physical fitness seems to have been gravely diminished.

3. Wounded and sick who have recovered, but whose mental or physical fitness seems to have been gravely and permanently diminished.

The following may be accommodated in a neutral country:

1. Wounded and sick whose recovery may be expected within one year of the date of the wound or the beginning of the illness, if treatment in a neutral country might increase the prospects of a more certain and speedy recovery.

2. Prisoners of war whose mental or physical health, according to medical opinion, is seriously threatened by continued captivity, but whose accommodation in a neutral country might remove such a threat.

The conditions which prisoners of war accommodated in a neutral country must fulfil in order to permit their repatriation shall be fixed, as shall likewise their status, by agreement between the Powers concerned. In general, prisoners of war who have been accommodated in a neutral country, and who belong to the following categories, should be repatriated:

The physician or surgeon of the same nationality as the prisoners who present themselves for examination by the Mixed Medical Commission, likewise the prisoners' representative of the said prisoners, shall have permission to be present at the examination.

Article 114

Prisoners of war who meet with accidents shall, unless the injury is self-inflicted, have the benefit of the provisions of this Convention as regards repatriation or accommodation in a neutral country.

Article 115

No prisoner of war on whom a disciplinary punishment has been imposed and who is eligible for repatriation or for accommodation in a neutral country, may be kept back on the plea that he has not undergone his punishment.

Prisoners of war detained in connection with a judicial prosecuti on or conviction and who are designated for repatriation or accommodation in a neutral country, may benefit by such measures before the end of the proceedings or the completion of the punishment, if the Detaining Power consents.

Parties to the conflict shall communicate to each other the names of those who will be detained until the end of the proceedings or the completion of the punishment.

Article 116

The costs of repatriating prisoners of war or of transporting them to a neutral country shall be borne, from the frontiers of the Detaining Power, by the Power on which the said prisoners depend.

Article 117

No repatriated person may be employed on active military service.

SECTION II

RELEASE AND REPATRIATION OF PRISONERS OF WAR AT THE CLOSE OF HOSTILITIES

Article 118

Prisoners of war shall be released and repatriated without delay after the cessation of active hostilities.

In the absence of stipulations to the above effect in any agreement concluded between the Parties to the conflict with a view to the cessation of hostilities, or failing any such agreement, each of the Detaining Powers shall itself establish and execute without delay a plan of repatriation in conformity with the principle laid down in the foregoing paragraph.

SECTION III

DEATH OF PRISONERS OF WAR

Article 120

Wills of prisoners of war shall be drawn up so as to satisfy the conditions of validity required by the legislation of their country of origin, which will take steps to inform the Detaining Power of its requirements in this respect. At the request of the prisoner of war and, in all cases, after death, the will shall be transmitted without delay to the Protecting Power; a certified copy shall be sent to the Central Agency.

Death certificates in the form annexed to the present Convention, or lists certified by a responsible officer, of all persons who die as prisoners of war shall be forwarded as rapidly as possible to the Prisoner of War Information Bureau established in accordance with Article 122. The death certificates or certified lists shall show particulars of identity as set out in the third paragraph of Article 17, and also the date and place of death, the cause of death, the date and place of burial and all particulars necessary to identify the graves.

The burial or cremation of a prisoner of war shall be preceded by a medical examination of the body with a view to confirming death and enabling a report to be made and, where necessary, establishing identity.

The detaining authorities shall ensure that prisoners of war who have died in captivity are honourably buried, if possible according to the rites of the religion to which they belonged, and that their graves are respected, suitably maintained and marked so as to be found at any time. Wherever possible, deceased prisoners of war who depended on the same Power shall be interred in the same place.

Deceased prisoners of war shall be buried in individual graves unless unavoidable circumstances require the use of collective graves. Bodies may be cremated only for imperative reasons of hygiene, on account of the religion of the deceased or in accordance with his express wish to this effect. In case of cremation, the fact shall be stated and the reasons given in the death certificate of the deceased.

In order that graves may always be found, all particulars of burials and graves shall be recorded with a Graves Registration Service established by the Detaining Power. Lists of graves and particulars of the prisoners of war interred in cemeteries and elsewhere shall be transmitted to the Power on which such prisoners of war depended. Responsibility for the care of these graves and for records of any subsequent moves of the bodies shall rest on the Power controlling the territory, if a Party to the present Convention. These provisions shall also apply to the ashes, which shall be kept by the Graves Registration Service until proper disposal thereof in accordance with the wishes of the home country.

Article 121

Every death or serious injury of a prisoner of war caused or suspected to have been caused by a sentry, another prisoner of war, or any other person, as well as any death the cause of which is unknown, shall be immediately followed by an official enquiry by the Detaining Power.

enquiries necessary to obtain the information which is asked for if this is not in its possession.

All written communications made by the Bureau shall be authenticated by a signature or a seal.

The Information Bureau shall furthermore be charged with collecting all personal valuables, including sums in currencies other than that of the Detaining Power and documents of importance to the next of kin, left by prisoners of war who have been repatriated or released, or who have escaped or died, and shall forward the said valuables to the Powers concerned. Such articles shall be sent by the Bureau in sealed packets which shall be accompanied by statements giving clear and full particulars of the identity of the person to whom the articles belonged, and by a complete list of the contents of the parcel. Other personal effects of such prisoners of war shall be transmitted under arrangements agreed upon between the Parties to the conflict concerned.

Article 123

A Central Prisoners of War Information Agency shall be created in a neutral country. The International Committee of the Red Cross shall, if it deems necessary, propose to the Powers concerned the organization of such an Agency.

The function of the Agency shall be to collect all the information it may obtain through official or private channels respecting prisoners of war, and to transmit it as rapidly as possible to the country of origin of the prisoners of war or to the Power on which they depend. It shall receive from the Parties to the conflict all facilities for effecting such transmissions.

The High Contracting Parties, and in particular those whose nationals benefit by the services of the Central Agency, are requested to give the said Agency the financial aid it may require.

The foregoing provisions shall in no way be interpreted as restricting the humanitarian activities of the International Committee of the Red Cross, or of the relief Societies provided for in Article 125.

Article 124

The national Information Bureaux and the Central Information Agency shall enjoy free postage for mail, likewise all the exemptions provided for in Article 74, and further, so far as possible, exemption from telegraphic charges or, at least, greatly reduced rates.

Article 125

Subject to the measures which the Detaining Powers may consider essential to ensure their security or to meet any other reasonable need, the representatives of religious organizations, relief societies, or any other organization assisting prisoners of war, shall receive from the said Powers, for themselves and their duly accredited agents, all necessary facilities for visiting the prisoners, distributing relief supplies and material, from any source, intended for religious, educational or recreative purposes, and for assisting them in organizing their leisure time within the camps. Such societies or organizations may be constituted in the territory of the Detaining Power or in any other country, or they may have an international character.

Any military or other authorities, who in time of war assume responsibilities in respect of prisoners of war, must possess the text of the Convention and be specially instructed as to its provisions.

Article 128

The High Contracting Parties shall communicate to one another through the Swiss Federal Council and, during hostilities, through the Protecting Powers, the official translations of the present Convention, as well as the laws and regulations which they may adopt to ensure the application thereof.

Article 129

The High Contracting Parties undertake to enact any legislation necessary to provide effective penal sanctions for persons committing, or ordering to be committed, any of the grave breaches of the present Convention defined in the following Article.

Each High Contracting Party shall be under the obligation to search for persons alleged to have committed, or to have ordered to be committed, such grave breaches, and shall bring such persons, regardless of their nationality, before its own courts. It may also, if it prefers, and in accordance with the provisions of its own legislation, hand such persons over for trial to another High Contracting Party concerned, provided such High Contracting Party has made out a prima facie case.

Each High Contracting Party shall take measures necessary for the suppression of all acts contrary to the provisions of the present Convention other than the grave breaches defined in the following Article.

In all circumstances, the accused persons shall benefit by safeguards of proper trial and defence, which shall not be less favourable than those provided by Article 105 and those following of the present Convention.

Article 130

Grave breaches to which the preceding Article relates shall be those involving any of the following acts, if committed against persons or property protected by the Convention: wilful killing, torture or inhuman treatment, including biological experiments, wilfully causing great suffering or serious injury to body or health, compelling a prisoner of war to serve in the forces of the hostile Power, or wilfully depriving a prisoner of war of the rights of fair and regular trial prescribed in this Convention.

Article 131

No High Contracting Party shall be allowed to absolve itself or any other High Contracting Party of any liability incurred by itself or by another High Contracting Party in respect of breaches referred to in the preceding Article.

Article 132

At the request of a Party to the conflict, an enquiry shall be instituted, in a manner to be

ratification have been deposited.

Thereafter, it shall come into force for each High Contracting Party six months after the deposit of the instrument of ratification.

Article 139

From the date of its coming into force, it shall be open to any Power in whose name the present Convention has not been signed, to accede to this Convention.

Article 140

Accessions shall be notified in writing to the Swiss Federal Council, and shall take effect six months after the date on which they are received.

The Swiss Federal Council shall communicate the accessions to all the Powers in whose name the Convention has been signed, or whose accession has been notified.

Article 141

The situations provided for in Articles 2 and 3 shall give immediate effect to ratifications deposited and accessions notified by the Parties to the conflict before or after the beginning of hostilities or occupation. The Swiss Federal Council shall communicate by the quickest method any ratifications or accessions received from Parties to the conflict.

Article 142

Each of the High Contracting Parties shall be at liberty to denounce the present Convention.

The denunciation shall be notified in writing to the Swiss Federal Council, which shall transmit it to the Governments of all the High Contracting Parties.

The denunciation shall take effect one year after the notification thereof has been made to the Swiss Federal Council. However, a denunciation of which notification has been made at a time when the denouncing Power is involved in a conflict shall not take effect until peace has been concluded, and until after operations connected with the release and repatriation of the persons protected by the present Convention have been terminated.

The denunciation shall have effect only in respect of the denouncing Power. It shall in no way impair the obligations which the Parties to the conflict shall remain bound to fulfil by virtue of the principles of the law of nations, as they result from the usages established among civilized peoples, from the laws of humanity and the dictates of the public conscience.

Article 143

The Swiss Federal Council shall register the present Convention with the Secretariat of the United Nations. The Swiss Federal Council shall also inform the Secretariat of the United Nations of all ratifications, accessions and denunciations received by it with respect to the present Convention.

(a) Projectile in the heart. even if the Mixed Medical Commission should fail, at the time of their examination, to detect any serious disorders.

(b) Metallic splinter in the brain or the lungs, even if the Mixed Medical Commission cannot, at the time of examination, detect any local or general reaction.

(c)Osteomyelitis, when recovery cannot be foreseen in the course of the year following the injury, and which seems likely to result in ankylosis of a joint, or other impairments equivalent to the loss of a hand or a foot.

(d) Perforating and suppurating injury to the large joints.

(e) Injury to the skull, with loss or shifting of bony tissue.

(f) Injury or burning of the face with loss of tissue and functional lesions.

(g) Injury to the spinal cord.

(h) Lesion of the peripheral nerves, the sequelae of which are equivalent to the loss of ahand or foot, and the cure of which requires more than a year from the date of injury, for example: injury to the brachial or lumbosacral plexus, the median or sciatic nerves, likewise combined injury to the radial and cubital nerves or to the lateral popliteal nerve *(N. peroneus communes)* and medial popliteal nerve *(N. tibialis);* etc. The separate injury of the 'radial (musculo-spiral), cubital. lateral or medial popliteal nerves shall not, however, warrant repatriation except in case of contractures or of serious neurotrophic disturbance.

(i) Injury to the urinary system, with incapacitating results.

3. All sick prisoners of war whose condition has become chronic to the extent that prognosis seems to exclude recovery-in spite of treatment-within one year from the inception of the disease, as, for example, in case of:

(a) Progressive tuberculosis of any organ which, according to medical prognosis, cannot be cured, or at least considerably improved, by treatment in a neutral country.

(b) Exudate pleurisy.

(c) Serious diseases of the respiratory organs of non-tubercular etiology, presumed incurable. for example: serious pulmonary emphysema, with or without bronchitis, chronic asthma:* chronic bronchitis* lasting more than one year in captivity; bronchiectasis,* etc.

(d) Serious chronic affections of the circulatory system, for example: valvular lesions and myocarditis* which have shown signs of circulatory failure during captivity, even though the Mixed Medical Commission cannot detect any such signs at the time of examination; affections of the pericardium and the vessels (Buerger's disease, aneurism of the large vessels); etc.

(e) Serious chronic affections of the digestive organs, for example: gastric or duodenal

*The decision of the Mixed Medical Commission shall be based to a great extent on the records kept by camp physicians and surgeons of the same nationality as the prisoners of war, or on an examination by medical specialists of the Detaining Power.

B. ACCOMMODATION IN NEUTRAL COUNTRIES

The following shall be eligible for accommodation in a neutral country:

1. All wounded prisoners of war who are not likely to recover in captivity, but who might be cured or whose condition might be considerably improved by accommodation in a neutral country.

2. Prisoners of war suffering from any form of tuberculosis, of whatever organ, and whose treatment in a neutral country would be likely to lead to recovery or at least to considerable improvement, with the exception of primary tuberculosis cured before captivity.

3. Prisoners of war suffering from affections requiring treatment of the respiratory, circulatory, digestive, nervous, sensory, genito-urinary, cutaneous. locomotive organs, etc., if such treatment would clearly have better results in a neutral country than in captivity.

4. Prisoners of war who have undergone a nephrectomy in captivity for a nontubercular renal affection; cases of osteomyelitis, on the way to recovery or latent; diabetes mellitus not requiring insulin treatment; etc.

5. Prisoners of war suffering from war or captivity neuroses.

Cases of captivity neurosis which are not cured after three months of accommodation in a neutral country, or which after that length of time are not clearly on the way to complete cure, shall be repatriated.

6. All prisoners of war suffering from chronic intoxication (gases, metals, alkaloids, etc.), for whom the prospects of cure in a neutral country are especially favourable.

7. All women prisoners of war who are pregnant or mothers with infants and small children.

ANNEX II

Regulations concerning Mixed Medical Commissions
(see Article 112)

Article 1

The Mixed Medical Commissions provided for in Article 112 of the Convention shall be composed of three members, two of whom shall belong to a neutral country. the third being appointed by the Detaining Power. One of the neutral members shall take the chair.

Article 2

The two neutral members shall be appointed by the International Committee of the Red Cross, acting in agreement with the Protecting Power, at the request of the Detaining Power. They may be domiciled either in their country of origin, in any other neutral country, or in the territory of the Detaining Power.

Article 3

The neutral members shall be approved by the Parties to the conflict concerned, who notify their approval to the International Committee of the Red Cross and to the Protecting Power. Upon such notification, the neutral members shall be considered as effectively appointed.

Article 4

Deputy members shall also be appointed in sufficient number to replace the regular members in case of need. They shall be appointed at the same time as the regular members or, at least, as soon as possible.

Article 5

If for any reason the International Committee of the Red Cross cannot arrange for the appointment of the neutral members, this shall be done by the Power protecting the interests of the prisoners of war to be examined.

Article 6

Commissions within three months of the time when it receives due notification of such decisions.

Article 13

If there is no neutral physician in a country where the services of a Mixed Medical Commission seem to be required, and if it is for any reason impossible to appoint neutral doctors who are resident in another country, the Detaining Power, acting in agreement with the Protecting Power, shall set up a Medical Commission which shall undertake the same duties as a Mixed Medical Commission, subject to the provisions of Articles 1, 2, 3, 4, 5 and 8 of the Present Regulations.

Article 14

Mixed Medical Commissions shall function permanently and shall visit each camp at intervals of not more than six months.

ANNEX III

Regulations concerning collective relief
(see Article 73)

Article 1

Prisoners' representatives shall be allowed to distribute collective relief shipments for which they are sible, to all prisoners of war administered by their camp, including those who am in hospitals or in prisons or other penal establishments.

Article 2

The distribution of collective relief shipments shall be effected in accordance with the instructions of the donors and with a plan drawn up by the prisoners' representatives. 'Me issue of medical stores shall. however, be made for preference in agreement with the senior medical officers, and the latter may. in hospitals and infirmaries, waive the said instructions, if the needs of their patients so demand. Within the limits thus defined, the distribution shall always be carried out equitably.

Article 3

The said prisoners' representatives or their assistants shall be allowed to go to the points of

possible and subject to the regulations governing the supply of the population, all purchases of goods made in their territories for the distribution of collective relief to prisoners of war. They shall similarly facilitate the transfer of funds and other financial measures of a technical or administrative nature taken for the purpose of making such purchases.

Article 9

The foregoing provisions shall not constitute an obstacle to the right of prisoners of war to receive collective relief before their arrival in a camp or in the course of transfer, nor to the possibility of representatives of the Protecting Power, the International Committee of the Red Cross, or any other body giving assistance to prisoners which may be responsible for the forwarding of such supplies, ensuring the distribution thereof to the addressees by any other means that they may deem useful.

ANNEX IV.

A. IDENTITYCARD
(see Article 4)

[...]

B. CAPTURE CARD
(see Article 70)

[...]

C. CORRESPONDENCE CARD AND LETTER
(see Article 71)

[...]

D. NOTIFICATION OF DEATH
(see Article 120)

[...]

E. REPATRIATION CERTIFICATE
(see Annex II, Article 11)

REPATRIATION CERTIFICATE

Date:

Camp:

Office of the United Nations High Commissioner for Human Rights
Geneva, Switzerland

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Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Text in PDF Format

Adopted by General Assembly resolution 3452 (XXX) of 9 December 1975

Article 1

1. For the purpose of this Declaration, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

2. Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment.

Article 2

Any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.

Article 3

No State may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment. Exceptional circumstances such as a state of war or a threat of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

Article 4

Each State shall, in accordance with the provisions of this Declaration, take effective measures to prevent torture and other cruel, inhuman or degrading treatment or punishment from being practised within its jurisdiction.

Article 5

The training of law enforcement personnel and of other public officials who may be responsible for persons deprived of their liberty shall ensure that full account is taken of the prohibition against torture and other cruel, inhuman or degrading treatment or punishment. This prohibition shall also, where appropriate, be included in such general rules or instructions as are issued in regard to the duties and functions of anyone who may be involved in the custody or treatment of such persons.

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International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976.

PREAMBLE

The States Parties to the present Covenant,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights,

Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,

Agree upon the following articles:

PART I

Article 1

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.

3. Any State Party to the present Covenant availing itself of the right of derogation shall immediately inform the other States Parties to the present Covenant, through the intermediary of the Secretary-General of the United Nations, of the provisions from which it has derogated and of the reasons by which it was actuated. A further communication shall be made, through the same intermediary, on the date on which it terminates such derogation.

Article 5

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms recognized herein or at their limitation to a greater extent than is provided for in the present Covenant.

2. There shall be no restriction upon or derogation from any of the fundamental human rights recognized or existing in any State Party to the present Covenant pursuant to law, conventions, regulations or custom on the pretext that the present Covenant does not recognize such rights or that it recognizes them to a lesser extent.

PART III

Article 6

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

2. In countries which have not abolished the death penalty, sentence of death may be imposed only for the most serious crimes in accordance with the law in force at the time of the commission of the crime and not contrary to the provisions of the present Covenant and to the Convention on the Prevention and Punishment of the Crime of Genocide. This penalty can only be carried out pursuant to a final judgement rendered by a competent court.

3. When deprivation of life constitutes the crime of genocide, it is understood that nothing in this article shall authorize any State Party to the present Covenant to derogate in any way from any obligation assumed under the provisions of the Convention on the Prevention and Punishment of the Crime of Genocide.

4. Anyone sentenced to death shall have the right to seek pardon or commutation of the sentence. Amnesty, pardon or commutation of the sentence of death may be granted in all cases.

5. Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women.

6. Nothing in this article shall be invoked to delay or to prevent the abolition of capital punishment by any State Party to the present Covenant.

Article 7

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or

appear for trial, at any other stage of the judicial proceedings, and, should occasion arise, for execution of the judgement.

4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

5. Anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation.

Article 10

1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

2.

(a) Accused persons shall, save in exceptional circumstances, be segregated from convicted persons and shall be subject to separate treatment appropriate to their status as unconvicted persons;

(b) Accused juvenile persons shall be separated from adults and brought as speedily as possible for adjudication. 3. The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation. Juvenile offenders shall be segregated from adults and be accorded treatment appropriate to their age and legal status.

Article 11

No one shall be imprisoned merely on the ground of inability to fulfil a contractual obligation.

Article 12

1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.

2. Everyone shall be free to leave any country, including his own.

3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant.

4. No one shall be arbitrarily deprived of the right to enter his own country.

Article 13

An alien lawfully in the territory of a State Party to the present Covenant may be expelled therefrom only in pursuance of a decision reached in accordance with law and shall, except

5. Everyone convicted of a crime shall have the right to his conviction and sentence being reviewed by a higher tribunal according to law.

6. When a person has by a final decision been convicted of a criminal offence and when subsequently his conviction has been reversed or he has been pardoned on the ground that a new or newly discovered fact shows conclusively that there has been a miscarriage of justice, the person who has suffered punishment as a result of such conviction shall be compensated according to law, unless it is proved that the non-disclosure of the unknown fact in time is wholly or partly attributable to him.

7. No one shall be liable to be tried or punished again for an offence for which he has already been finally convicted or acquitted in accordance with the law and penal procedure of each country.

Article 15

1 . No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time when the criminal offence was committed. If, subsequent to the commission of the offence, provision is made by law for the imposition of the lighter penalty, the offender shall benefit thereby.

2. Nothing in this article shall prejudice the trial and punishment of any person for any act or omission which, at the time when it was committed, was criminal according to the general principles of law recognized by the community of nations.

Article 16

Everyone shall have the right to recognition everywhere as a person before the law.

Article 17

1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.

2. Everyone has the right to the protection of the law against such interference or attacks.

Article 18

1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or

Organisation Convention of 1948 concerning Freedom of Association and Protection of the Right to Organize to take legislative measures which would prejudice, or to apply the law in such a manner as to prejudice, the guarantees provided for in that Convention.

Article 23

1. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

2. The right of men and women of marriageable age to marry and to found a family shall be recognized.

3. No marriage shall be entered into without the free and full consent of the intending spouses.

4. States Parties to the present Covenant shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution. In the case of dissolution, provision shall be made for the necessary protection of any children.

Article 24

1. Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.

2. Every child shall be registered immediately after birth and shall have a name.

3. Every child has the right to acquire a nationality.

Article 25

Every citizen shall have the right and the opportunity, without any of the distinctions mentioned in article 2 and without unreasonable restrictions:

(a) To take part in the conduct of public affairs, directly or through freely chosen representatives;

(b) To vote and to be elected at genuine periodic elections which shall be by universal and equal suffrage and shall be held by secret ballot, guaranteeing the free expression of the will of the electors;

(c) To have access, on general terms of equality, to public service in his country.

Article 26

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as

4. Elections of the members of the Committee shall be held at a meeting of the States Parties to the present Covenant convened by the Secretary General of the United Nations at the Headquarters of the United Nations. At that meeting, for which two thirds of the States Parties to the present Covenant shall constitute a quorum, the persons elected to the Committee shall be those nominees who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

Article 31

1. The Committee may not include more than one national of the same State.

2. In the election of the Committee, consideration shall be given to equitable geographical distribution of membership and to the representation of the different forms of civilization and of the principal legal systems.

Article 32

1. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. However, the terms of nine of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these nine members shall be chosen by lot by the Chairman of the meeting referred to in article 30, paragraph 4.

2. Elections at the expiry of office shall be held in accordance with the preceding articles of this part of the present Covenant.

Article 33

1. If, in the unanimous opinion of the other members, a member of the Committee has ceased to carry out his functions for any cause other than absence of a temporary character, the Chairman of the Committee shall notify the Secretary-General of the United Nations, who shall then declare the seat of that member to be vacant.

2. In the event of the death or the resignation of a member of the Committee, the Chairman shall immediately notify the Secretary-General of the United Nations, who shall declare the seat vacant from the date of death or the date on which the resignation takes effect.

Article 34

1. When a vacancy is declared in accordance with article 33 and if the term of office of the member to be replaced does not expire within six months of the declaration of the vacancy, the Secretary-General of the United Nations shall notify each of the States Parties to the present Covenant, which may within two months submit nominations in accordance with article 29 for the purpose of filling the vacancy.

2. The Secretary-General of the United Nations shall prepare a list in alphabetical order of the persons thus nominated and shall submit it to the States Parties to the present Covenant. The election to fill the vacancy shall then take place in accordance with the relevant provisions of this part of the present Covenant.

(a) Within one year of the entry into force of the present Covenant for the States Parties concerned;

(b) Thereafter whenever the Committee so requests.

2. All reports shall be submitted to the Secretary-General of the United Nations, who shall transmit them to the Committee for consideration. Reports shall indicate the factors and difficulties, if any, affecting the implementation of the present Covenant.

3. The Secretary-General of the United Nations may, after consultation with the Committee, transmit to the specialized agencies concerned copies of such parts of the reports as may fall within their field of competence.

4. The Committee shall study the reports submitted by the States Parties to the present Covenant. It shall transmit its reports, and such general comments as it may consider appropriate, to the States Parties. The Committee may also transmit to the Economic and Social Council these comments along with the copies of the reports it has received from States Parties to the present Covenant.

5. The States Parties to the present Covenant may submit to the Committee observations on any comments that may be made in accordance with paragraph 4 of this article.

Article 41

1. A State Party to the present Covenant may at any time declare under this article that it recognizes the competence of the Committee to receive and consider communications to the effect that a State Party claims that another State Party is not fulfilling its obligations under the present Covenant. Communications under this article may be received and considered only if submitted by a State Party which has made a declaration recognizing in regard to itself the competence of the Committee. No communication shall be received by the Committee if it concerns a State Party which has not made such a declaration. Communications received under this article shall be dealt with in accordance with the following procedure:

(a) If a State Party to the present Covenant considers that another State Party is not giving effect to the provisions of the present Covenant, it may, by written communication, bring the matter to the attention of that State Party. Within three months after the receipt of the communication the receiving State shall afford the State which sent the communication an explanation, or any other statement in writing clarifying the matter which should include, to the extent possible and pertinent, reference to domestic procedures and remedies taken, pending, or available in the matter;

(b) If the matter is not adjusted to the satisfaction of both States Parties concerned within six months after the receipt by the receiving State of the initial communication, either State shall have the right to refer the matter to the Committee, by notice given to the Committee and to the other State;

(c) The Committee shall deal with a matter referred to it only after it has ascertained that all available domestic remedies have been invoked and

resolved to the satisfaction of the States Parties concerned, the Committee may, with the prior consent of the States Parties concerned, appoint an ad hoc Conciliation Commission (hereinafter referred to as the Commission). The good offices of the Commission shall be made available to the States Parties concerned with a view to an amicable solution of the matter on the basis of respect for the present Covenant;

(b) The Commission shall consist of five persons acceptable to the States Parties concerned. If the States Parties concerned fail to reach agreement within three months on all or part of the composition of the Commission, the members of the Commission concerning whom no agreement has been reached shall be elected by secret ballot by a two-thirds majority vote of the Committee from among its members.

2. The members of the Commission shall serve in their personal capacity. They shall not be nationals of the States Parties concerned, or of a State not Party to the present Covenant, or of a State Party which has not made a declaration under article 41.

3. The Commission shall elect its own Chairman and adopt its own rules of procedure.

4. The meetings of the Commission shall normally be held at the Headquarters of the United Nations or at the United Nations Office at Geneva. However, they may be held at such other convenient places as the Commission may determine in consultation with the Secretary-General of the United Nations and the States Parties concerned.

5. The secretariat provided in accordance with article 36 shall also service the commissions appointed under this article.

6. The information received and collated by the Committee shall be made available to the Commission and the Commission may call upon the States Parties concerned to supply any other relevant information. 7. When the Commission has fully considered the matter, but in any event not later than twelve months after having been seized of the matter, it shall submit to the Chairman of the Committee a report for communication to the States Parties concerned:

(a) If the Commission is unable to complete its consideration of the matter within twelve months, it shall confine its report to a brief statement of the status of its consideration of the matter;

(b) If an amicable solution to the matter on tie basis of respect for human rights as recognized in the present Covenant is reached, the Commission shall confine its report to a brief statement of the facts and of the solution reached;

(c) If a solution within the terms of subparagraph (b) is not reached, the Commission's report shall embody its findings on all questions of fact relevant to the issues between the States Parties concerned, and its views on the possibilities of an amicable solution of the matter. This report shall also contain the written submissions and a record of the oral submissions made by the States Parties concerned;

PART VI

Article 48

1. The present Covenant is open for signature by any State Member of the United Nations or member of any of its specialized agencies, by any State Party to the Statute of the International Court of Justice, and by any other State which has been invited by the General Assembly of the United Nations to become a Party to the present Covenant.

2. The present Covenant is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

3. The present Covenant shall be open to accession by any State referred to in paragraph 1 of this article.

4. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

5. The Secretary-General of the United Nations shall inform all States which have signed this Covenant or acceded to it of the deposit of each instrument of ratification or accession.

Article 49

1. The present Covenant shall enter into force three months after the date of the deposit with the Secretary-General of the United Nations of the thirty-fifth instrument of ratification or instrument of accession.

2. For each State ratifying the present Covenant or acceding to it after the deposit of the thirty-fifth instrument of ratification or instrument of accession, the present Covenant shall enter into force three months after the date of the deposit of its own instrument of ratification or instrument of accession.

Article 50

The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions.

Article 51

1. Any State Party to the present Covenant may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General of the United Nations shall thereupon communicate any proposed amendments to the States Parties to the present Covenant with a request that they notify him whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that at least one third of the States Parties favours such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States Parties present and voting at the conference shall be submitted to the General Assembly of the United Nations for approval.

2. Amendments shall come into force when they have been approved by the General

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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

Adopted by General Assembly resolution 37/194 of 18 December 1982

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2

It is a gross contravention of medical ethics, as well as 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 or other cruel, inhuman or degrading treatment or punishment. 1

Principle 3

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

Principle 4

It is a contravention of medical ethics for health personnel, particularly physicians:

(a) To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments; 2

(b) To certify, or to participate in the certification of, the fitness 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.

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary 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.

Principle 6

There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency.

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Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)], *entered into force* June 26, 1987.

The States Parties to this Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that those rights derive from the inherent dignity of the human person,

Considering the obligation of States under the Charter, in particular Article 55, to promote universal respect for, and observance of, human rights and fundamental freedoms,

Having regard to article 5 of the Universal Declaration of Human Rights and article 7 of the International Covenant on Civil and Political Rights, both of which provide that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment,

Having regard also to the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the General Assembly on 9 December 1975,

Desiring to make more effective the struggle against torture and other cruel, inhuman or degrading treatment or punishment throughout the world,

Have agreed as follows:

PART I

Article 1

1. For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

under its jurisdiction and it does not extradite him pursuant to article 8 to any of the States mentioned in paragraph 1 of this article.

3. This Convention does not exclude any criminal jurisdiction exercised in accordance with internal law.

Article 6

1. Upon being satisfied, after an examination of information available to it, that the circumstances so warrant, any State Party in whose territory a person alleged to have committed any offence referred to in article 4 is present shall take him into custody or take other legal measures to ensure his presence. The custody and other legal measures shall be as provided in the law of that State but may be continued only for such time as is necessary to enable any criminal or extradition proceedings to be instituted.

2. Such State shall immediately make a preliminary inquiry into the facts.

3. Any person in custody pursuant to paragraph 1 of this article shall be assisted in communicating immediately with the nearest appropriate representative of the State of which he is a national, or, if he is a stateless person, with the representative of the State where he usually resides.

4. When a State, pursuant to this article, has taken a person into custody, it shall immediately notify the States referred to in article 5, paragraph 1, of the fact that such person is in custody and of the circumstances which warrant his detention. The State which makes the preliminary inquiry contemplated in paragraph 2 of this article shall promptly report its findings to the said States and shall indicate whether it intends to exercise jurisdiction.

Article 7

1. The State Party in the territory under whose jurisdiction a person alleged to have committed any offence referred to in article 4 is found shall in the cases contemplated in article 5, if it does not extradite him, submit the case to its competent authorities for the purpose of prosecution.

2. These authorities shall take their decision in the same manner as in the case of any ordinary offence of a serious nature under the law of that State. In the cases referred to in article 5, paragraph 2, the standards of evidence required for prosecution and conviction shall in no way be less stringent than those which apply in the cases referred to in article 5, paragraph 1.

3. Any person regarding whom proceedings are brought in connection with any of the offences referred to in article 4 shall be guaranteed fair treatment at all stages of the proceedings.

Article 8

1. The offences referred to in article 4 shall be deemed to be included as extraditable offences in any extradition treaty existing between States Parties. States Parties undertake to

Article 13

Each State Party shall ensure that any individual who alleges he has been subjected to torture in any territory under its jurisdiction has the right to complain to, and to have his case promptly and impartially examined by, its competent authorities. Steps shall be taken to ensure that the complainant and witnesses are protected against all ill-treatment or intimidation as a consequence of his complaint or any evidence given.

Article 14

1. Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.

2. Nothing in this article shall affect any right of the victim or other persons to compensation which may exist under national law.

Article 15

Each State Party shall ensure that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made.

Article 16

1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment or which relates to extradition or expulsion.

PART II

Article 17

1. There shall be established a Committee against Torture (hereinafter referred to as the Committee) which shall carry out the functions hereinafter provided. The Committee shall consist of ten experts of high moral standing and recognized competence in the field of human rights, who shall serve in their personal capacity. The experts shall be elected by the States Parties, consideration being given to equitable geographical distribution and to the usefulness of the participation of some persons having legal experience.

2. The members of the Committee shall be elected by secret ballot from a list of persons

4. The Secretary-General of the United Nations shall convene the initial meeting of the Committee. After its initial meeting, the Committee shall meet at such times as shall be provided in its rules of procedure.

5. The States Parties shall be responsible for expenses incurred in connection with the holding of meetings of the States Parties and of the Committee, including reimbursement to the United Nations for any expenses, such as the cost of staff and facilities, incurred by the United Nations pursuant to paragraph 3 of this article.

Article 19

1. The States Parties shall submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have taken to give effect to their undertakings under this Convention, within one year after the entry into force of the Convention for the State Party concerned. Thereafter the States Parties shall submit supplementary reports every four years on any new measures taken and such other reports as the Committee may request.

2. The Secretary-General of the United Nations shall transmit the reports to all States Parties.

3. Each report shall be considered by the Committee which may make such general comments on the report as it may consider appropriate and shall forward these to the State Party concerned. That State Party may respond with any observations it chooses to the Committee.

4. The Committee may, at its discretion, decide to include any comments made by it in accordance with paragraph 3 of this article, together with the observations thereon received from the State Party concerned, in its annual report made in accordance with article 24. If so requested by the State Party concerned, the Committee may also include a copy of the report submitted under paragraph I of this article.

Article 20

1. If the Committee receives reliable information which appears to it to contain well-founded indications that torture is being systematically practised in the territory of a State Party, the Committee shall invite that State Party to co-operate in the examination of the information and to this end to submit observations with regard to the information concerned.

2. Taking into account any observations which may have been submitted by the State Party concerned, as well as any other relevant information available to it, the Committee may, if it decides that this is warranted, designate one or more of its members to make a confidential inquiry and to report to the Committee urgently.

3. If an inquiry is made in accordance with paragraph 2 of this article, the Committee shall seek the co-operation of the State Party concerned. In agreement with that State Party, such an inquiry may include a visit to its territory.

4. After examining the findings of its member or members submitted in accordance with

appropriate, set up an ad hoc conciliation commission;

(f) In any matter referred to it under this article, the Committee may call upon the States Parties concerned, referred to in subparagraph (b), to supply any relevant information;

(g) The States Parties concerned, referred to in subparagraph (b), shall have the right to be represented when the matter is being considered by the Committee and to make submissions orally and/or in writing;

(h) The Committee shall, within twelve months after the date of receipt of notice under subparagraph (b), submit a report:

(i) If a solution within the terms of subparagraph (e) is reached, the Committee shall confine its report to a brief statement of the facts and of the solution reached;

(ii) If a solution within the terms of subparagraph (e) is not reached, the Committee shall confine its report to a brief statement of the facts; the written submissions and record of the oral submissions made by the States Parties concerned shall be attached to the report. In every matter, the report shall be communicated to the States Parties concerned.

2. The provisions of this article shall come into force when five States Parties to this Convention have made declarations under paragraph 1 of this article. Such declarations shall be deposited by the States Parties with the Secretary-General of the United Nations, who shall transmit copies thereof to the other States Parties. A declaration may be withdrawn at any time by notification to the Secretary-General. Such a withdrawal shall not prejudice the consideration of any matter which is the subject of a communication already transmitted under this article; no further communication by any State Party shall be received under this article after the notification of withdrawal of the declaration has been received by the Secretary-General, unless the State Party concerned has made a new declaration.

Article 22

1. A State Party to this Convention may at any time declare under this article that it recognizes the competence of the Committee to receive and consider communications from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State Party of the provisions of the Convention. No communication shall be received by the Committee if it concerns a State Party which has not made such a declaration.

2. The Committee shall consider inadmissible any communication under this article which is anonymous or which it considers to be an abuse of the right of submission of such communications or to be incompatible with the provisions of this Convention.

3. Subject to the provisions of paragraph 2, the Committee shall bring any communications submitted to it under this article to the attention of the State Party to this Convention which has made a declaration under paragraph I and is alleged to be violating any provisions of the Convention. Within six months, the receiving State shall submit to the Committee written

ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 26

This Convention is open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the SecretaryGeneral of the United Nations.

Article 27

1. This Convention shall enter into force on the thirtieth day after the date of the deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying this Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

Article 28

1. Each State may, at the time of signature or ratification of this Convention or accession thereto, declare that it does not recognize the competence of the Committee provided for in article 20.

2. Any State Party having made a reservation in accordance with paragraph I of this article may, at any time, withdraw this reservation by notification to the Secretary-General of the United Nations.

Article 29

1 . Any State Party to this Convention may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary General shall thereupon communicate the proposed amendment to the States Parties with a request that they notify him whether they favour a conference of States Parties for the purpose of considering and voting upon the proposal. In the event that within four months from the date of such communication at least one third of the States Parties favours such a conference, the Secretary General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States Parties present and voting at the conference shall be submitted by the Secretary-General to all the States Parties for acceptance.

2. An amendment adopted in accordance with paragraph I of this article shall enter into force when two thirds of the States Parties to this Convention have notified the Secretary-General of the United Nations that they have accepted it in accordance with their respective constitutional processes.

3. When amendments enter into force, they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of this Convention and any earlier amendments which they have accepted.

2. The Secretary-General of the United Nations shall transmit certified copies of this Convention to all States.

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Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Istanbul Protocol

Submitted to the
United Nations High Commissioner for Human Rights

9 August 1999

PARTICIPATING ORGANIZATIONS

Action for Torture Survivors (HRFT), Geneva
Amnesty International, London
Association for the Prevention of Torture, Geneva
Behandlungszentrum für Folteropfer, Berlin
British Medical Association (BMA), London
Center for Research and Application of Philosophy and Human Rights, Hacettepe University, Ankara
Center for the Study of Society and Medicine, Columbia University, New York
The Center for Victims of Torture (CVT), Minneapolis
Centre Georges Devereux, University of Paris VIII, Paris
Committee against Torture, Geneva
Danish Medical Association, Copenhagen
Department of Forensic Medicine and Toxicology, University of Colombo, Colombo
Ethics Department, Dokuz Eylül Medical Faculty, Izmir
Gaza Community Mental Health Programme, Gaza
German Medical Association, Berlin
Human Rights Foundation of Turkey (HRFT), Ankara
Human Rights Watch, New York
Indian Medical Association and the IRCT, New Delhi
Indochinese Psychiatric Clinic, Boston
Institute for Global Studies, University of Minnesota, Minneapolis
Instituto Latinoamericano de Salud Mental, Santiago, Chile
International Committee of the Red Cross, Geneva
International Federation of Health and Human Rights Organizations, Amsterdam
International Rehabilitation Council for Torture Victims (IRCT), Copenhagen
Johannes Wier Foundation, Amsterdam
Lawyers Committee for Human Rights, New York
The Medical Foundation for the Care of Victims of Torture, London
Physicians for Human Rights Israel, Tel Aviv
Physicians for Human Rights Palestine, Gaza
Physicians for Human Rights USA, Boston
Program for the Prevention of Torture, Inter-American Institute of Human Rights, San José
Society of Forensic Medicine Specialists, Istanbul
Survivors International, San Francisco
The Trauma Centre for Survivors of Violence and Torture, Cape Town
Turkish Medical Association, Ankara
Special Rapporteur on Torture, Geneva
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INTRODUCTION

Torture is defined in this manual in the words of the United Nations Convention against Torture, 1984:

> "Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."[1]

Torture is a profound concern of the world community. Its purpose is to destroy deliberately not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of entire communities. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future.[2]

Although international human rights and humanitarian law consistently prohibit torture under any circumstance (see chapter I), torture and ill-treatment are practised in more than half of the world's countries.[3,4] The striking disparity between the absolute prohibition of torture and its prevalence in the world today demonstrates the need for States to identify and implement effective measures to protect individuals from torture and ill-treatment. This manual was developed to enable States to address one of the most fundamental concerns in protecting individuals from torture—effective documentation. Such documentation brings evidence of torture and ill-treatment to light so that perpetrators may be held accountable for their actions and the interests of justice may be served. The documentation methods contained in this manual are also applicable to other contexts, including human rights investigations and monitoring, political asylum evaluations, the defence of individuals who "confess" to crimes during torture and needs assessments for the care of torture victims, among others. In the case of health professionals who are coerced into neglect, misrepresention or falsification of evidence of torture, this manual also provides an international point of reference for health professionals and adjudicators alike.

During the past two decades, much has been learned about torture and its consequences, but no international guidelines for documentation were available prior to the development of this manual. The *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (the Istanbul Protocol) is intended to serve as international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body. This manual includes principles for the effective investigation and documentation of torture, and other cruel, inhuman or degrading treatment or punishment (see annex I). These principles outline minimum standards for States in order to ensure the effective documentation of torture.[5] The guidelines contained in this manual are not presented as a

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[1] The Board of Trustees of the United Nations Voluntary Fund for Victims of Torture has recently decided that, for the purposes of its work, it will use the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

[2] V. Iacopino, "Treatment of survivors of political torture: commentary", *The Journal of Ambulatory Care Management*, 21(2) 1998:5–13.

[3] Amnesty International, *Amnesty International Report 1999* (London, AIP, 1999).

[4] M. Baĺo»lu, "Prevention of torture and care of survivors: an integrated approach", *The Journal of the American Medical Association (JAMA)*, 270 1993:606–611.

[5] The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment have been annexed to the General Assembly resolution 55/89 (4 December 2000) and the Commission on Human Rights resolution 2000/43 (20 April 2000), both adopted without voting.

CHAPTER I

RELEVANT INTERNATIONAL LEGAL STANDARDS

1. The right to be free from torture is firmly established under international law. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment all expressly prohibit torture. Similarly, several regional instruments establish the right to be free from torture. The American Convention on Human Rights, the African Charter on Human and Peoples' Rights and the Convention for the Protection of Human Rights and Fundamental Freedoms all contain express prohibitions of torture.

A. International humanitarian law

2. The international treaties governing armed conflicts establish international humanitarian law or the law of war. The prohibition of torture under international humanitarian law is only a small, but important, part of the wider protection these treaties provide for all victims of war. The four Geneva Conventions of 1949 have been ratified by 188 States. They establish rules for the conduct of international armed conflict and, especially, for the treatment of persons who do not, or who no longer, take part in hostilities, including the wounded, the captured and civilians. All four conventions prohibit the infliction of torture and other forms of ill-treatment. Two Protocols of 1977, additional to the Geneva Conventions, expand the protection and scope of these conventions. Protocol I (ratified to date by 153 States) covers international conflicts. Protocol II (ratified to date by 145 States) covers non-international conflicts.

3. More important to the purpose here, however, is what is known as "Common Article 3", found in all four conventions. Common Article 3 applies to armed conflicts "not of an international character", no further definition being given. It is taken to define core obligations that must be respected in all armed conflicts and not just in international wars between countries. This is generally taken to mean that no matter what the nature of a war or conflict, certain basic rules cannot be abrogated. The prohibition of torture is one of these and represents an element common to international humanitarian law and human rights law.

4. Common Article 3 states:

> . . . the following acts are and shall remain prohibited at any time and in any place whatsoever . . . violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; . . . outrages upon personal dignity, in particular humiliating and degrading treatment . . .

5. As the Special Rapporteur on Torture, Nigel Rodley, has stated:

> The prohibition of torture or other ill-treatment could hardly be formulated in more absolute terms. In the words of the official commentary on the text by the International Committee of the Red Cross (ICRC), no possible loophole is left; there can be no excuse, no attenuating circumstances.[6]

6. A further link between international humanitarian law and human rights law is found in the preamble to Protocol II, which itself regulates non-international armed conflicts (such as fully-fledged civil wars), and which states that: ". . . international instruments relating to human rights offer a basic protection to the human person."[7]

B. The United Nations

7. To ensure adequate protection for all persons against torture or cruel, inhuman or degrading treatment, the United Nations has sought for many years to develop universally applicable standards. The conventions, declarations and resolutions adopted by the Member States of the United Nations clearly state that there may be no exception to the prohibition of torture and establish other obligations to ensure protection against such abuses. Among the most important of these instruments are the Universal Declaration of Human Rights (UDHR),[8] the International Covenant on Civil and Political Rights (ICCPR),[9] the Standard Minimum Rules for the Treatment of Prisoners (SMRTP),[10] the United Nations Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration on the Protection

[6] N. Rodley, *The Treatment of Prisoners under International Law*, 2nd ed. (Oxford, Clarendon Press, 1999:58).

[7] Second preambular paragraph of Protocol II (1977), additional to the Geneva Conventions of 1949.

[8] General Assembly resolution 217 A (III), United Nations document A/810 at 71 (1948), article 5.

[9] General Assembly resolution 2200 A (XXI), 21 United Nations GAOR Supp. (No. 16) at 52, United Nations document A/6316 (1966), 999 United Nations *Treaty Series* 171, which entered into force on 23 March 1976, article 7.

[10] Adopted on 30 August 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, United Nations document A/CONF/611, annex I, Economic and Social Council resolution 663 C, 24 United Nations ESCOR Supp. (No. 1) at 11, United Nations document E/3048 (1957), amended by Economic and Social Council resolution 2076, 62 United Nations ESCOR Supp. (No. 1) at 35, United Nations document E/5988 (1977), article 31.

lishes that an act of torture appears to have been committed. If an allegation of other forms of cruel, inhuman or degrading treatment or punishment is considered to be well founded, the alleged offender or offenders shall be subject to criminal, disciplinary or other appropriate proceedings (art. 7 of the Convention against Torture, art. 10 of the Declaration on the Protection against Torture).

2. *United Nations bodies and mechanisms*

(a) *Committee against Torture*

11. The Committee against Torture monitors implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Committee consists of 10 experts appointed because of their "high moral standing and recognized competence in the field of human rights". Under article 19 of the Convention against Torture, the States parties submit to the Committee, through the Secretary-General, reports on the measures they have taken to give effect to their undertakings under the Convention. The Committee examines how the provisions of the Convention have been incorporated into domestic law and monitors how this functions in practice. Each report is considered by the Committee, which may make general comments and recommendations and include this information in its annual report to the States parties and to the General Assembly. These procedures take place in public meetings.

12. Under article 20 of the Convention against Torture, if the Committee receives reliable information that appears to contain well-founded indications that torture is being systematically practised in the territory of a State party, the Committee must invite that State party to cooperate in the examination of the information and, to this end, to submit observations with regard to the information concerned. The Committee may, if it decides that this is warranted, designate one or more of its members to make a confidential inquiry and to report to the Committee urgently. In agreement with that State party, that inquiry may include a visit to its territory. After examining the findings of its member or members, the Committee transmits these findings to the State party concerned together with any comments or suggestions that seem appropriate in view of the situation. All the proceedings of the Committee under article 20 are confidential, and, at all stages of the proceedings, the cooperation of the State party is sought. After completion of these proceedings, the Committee may, after consultations with the State party concerned, decide to include a summary account of the results of the proceedings in its annual report to the other States parties and to the General Assembly.[18]

13. Under article 22 of the Convention against Torture, a State party may at any time recognize the competence of the Committee to receive and consider individual complaints from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State party of the provisions of the Convention against Torture. The Committee then considers these communications confidentially and shall forward its view to the State party concerned and to the individual. Only 39 of the 112 States parties that have ratified the Convention have also recognized the applicability of article 22.

14. Among the concerns addressed by the Committee in its annual reports to the General Assembly is the necessity of States parties to comply with articles 12 and 13 on the Convention against Torture to ensure that prompt and impartial investigations of all complaints of torture are undertaken. For example, the Committee has stated that it considers a delay of 15 months in investigating allegations of torture to be unreasonably long and not in compliance with article 12.[19] The Committee has also noted that article 13 does not require a formal submission of a complaint of torture, but that "it is sufficient for torture only to have been alleged by the victim for [a State Party] to be under an obligation promptly and impartially to examine the allegation".[20]

(b) *Human Rights Committee*

15. The Human Rights Committee was established pursuant to article 28 of the International Covenant on Civil and Political Rights and the requirement to monitor implementation of the Covenant in the States parties. The Committee is composed of 18 independent experts who are expected to be persons of high moral character and of recognized competence in the field of human rights.

16. States parties to the Covenant must submit reports every five years on the measures they have adopted to give effect to the rights recognized in the Covenant and on progress made in the enjoyment of those rights. The Human Rights Committee examines the reports through a dialogue with representatives of the State party whose report is under consideration. The Committee then adopts concluding observations summarizing its main concerns and making appropriate suggestions and recommendations to the State party. The Committee also prepares general comments interpreting specific articles of the Covenant to guide States parties in their reporting, as well as their implementation of the Covenant's provisions. In one such general comment, the Committee undertook to clarify article 7 of the International Covenant on Civil and Political Rights, which states that no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. In the general comments on article 7 of the Covenant in the report of the Committee, it specifically noted that prohibiting torture or making it a crime is not sufficient implementation of article 7.[21] The Committee stated: "... States must ensure an effective protection through some machinery of control. Complaints about ill-treatment must be investigated effectively by competent authorities."

[18] It should be pointed out, however, that application of article 20 can be limited because of a reservation by a State party, in which case article 20 is not applicable.

[19] See Communication 8/1991, paragraph 185, reported in the General Assembly report of the Committee against Torture (A/49/44) of 12 June 1994.

[20] See Communication 6/1990, paragraph 10.4, reported in the General Assembly report of the Committee against Torture (A/50/44) of 26 July 1995.

[21] United Nations document A/37/40 (1982).

23. The Special Rapporteur reports annually to the Commission on Human Rights on communications sent to governments and on replies received by him or her. On the basis of information received from governments and other reliable sources, the Special Rapporteur makes recommendations to the governments concerned with a view to finding durable solutions to the elimination of violence against women in any country. The Special Rapporteur may send follow-up communications to governments when no replies have been received or when insufficient information was provided. Should a particular situation of violence against women in any given country persist and information received by the Special Rapporteur indicate that no measures are or have been taken by a government to ensure the protection of the human rights of women, the Special Rapporteur may consider the possibility of seeking permission from the government concerned to visit that country in order to carry out an on-site fact-finding mission.

C. Regional organizations

24. Regional bodies have also contributed to the development of standards for the prevention of torture. These bodies include the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Court of Human Rights, the European Committee for the Prevention of Torture and the African Commission on Human Rights.

1. *The Inter-American Commission on Human Rights and the Inter-American Court of Human Rights*

25. On 22 November 1969, the Organization of American States adopted the American Convention on Human Rights, which entered into force on 18 July 1978.[25] Article 5 of the Convention states:

> 1. Every person has the right to have his physical, mental, and moral integrity respected.
>
> 2. No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.

26. Article 33 of the Convention provides for the establishment of the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. As stated in its regulations, the Commission's principal function is to promote the observance and defence of human rights and to serve as an advisory body to the Organization of American States in this area.[26] In fulfilling this function, the Commission has looked to the Inter-American Convention to Prevent and Punish Torture to guide its interpretation of what is meant by torture under article 5.[27] The Inter-American Convention to Prevent and Punish Torture was adopted by the Organization of American States on 9 December 1985 and entered into force on 28 February 1987.[28] Article 2 of the Convention defines torture as:

> . . . any act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.

27. Under article 1, the States parties to the Convention undertake to prevent and punish torture in accordance with the terms of the Convention. States parties to the Convention are required to conduct an immediate and proper investigation into any allegation that torture has occurred within their jurisdiction.

28. Article 8 provides that "States Parties shall guarantee that any person making an accusation of having been subjected to torture within their jurisdiction shall have the right to an impartial examination of his case". Likewise, if there is an accusation or well-grounded reason to believe that an act of torture has been committed within their jurisdiction, the States parties must guarantee that their respective authorities will proceed properly and immediately to conduct an investigation into the case and to initiate, whenever appropriate, the corresponding criminal process.

29. In one of its 1998 country reports, the Commission noted that an obstacle to the effective prosecution of torturers is the lack of independence in an investigation of claims of torture, as the investigation is required to be undertaken by federal bodies likely to be acquainted with parties accused of committing torture.[29] The Commission cited article 8 to underscore the importance of an "impartial examination" of each case.[30]

30. The Inter-American Court of Human Rights has addressed the necessity of investigating claims of violations of the American Convention on Human Rights. In its decision in the Velasquez Rodriguez case, judgement of 29 July 1988, the Court stated that:

> The State is obligated to investigate every situation involving a violation of the rights protected by the Convention. If the State apparatus acts in such a way that the violation goes unpunished and the victim's full enjoyment of such rights is not restored as soon as possible, the State has failed to comply with its duty to ensure the free and full exercise of those rights to the persons within its jurisdiction.

31. Article 5 of the Convention provides for the right to be free from torture. Although the case dealt specifically with the issue of disappearance, one of the rights referred to by the court as guaranteed by the American Convention on Human Rights is the right not to be subjected to torture or other forms of ill-treatment.

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[25] Organization of American States Treaty Series No. 36, 1144 United Nations *Treaty Series* 123, which entered into force on 18 July 1978, reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82, document 6, rev. 1, at 25 (1992).

[26] Regulations of the Inter-American Commission on Human Rights, Organization of American States Series L.V/II.92, document 31, revision 3 of 3 May 1996 at article 1 (1).

[27] See case 10.832, report No. 35/96, Inter-American Commission on Human Rights Annual Report 1997 at paragraph 75.

[28] Organization of American States Treaty Series No. 67.

[29] Report on the Situation of Human Rights in Mexico, 1998, the Inter-American Commission on Human Rights at paragraph 323.

[30] Ibid. at paragraph 324.

should be of high moral standard, impartial, independent and also available to carry out field missions.

39. The Committee carries out visits to member States of the Council of Europe, partially on a regular periodic basis and partially on an ad hoc basis. A visiting delegation of the Committee consists of members of the Committee, accompanying experts in the medical, legal or other fields, interpreters and members of the Secretariat. These delegations visit persons deprived of their liberty by the authorities of the country visited.[43] The powers of each visiting delegation are quite vast: it may visit any place where persons are held deprived of their liberty; make unannounced visits to any such place; repeat visits to these places; talk to persons deprived of their liberty in private; visit any or all persons it chooses to in these places; and see all premises (not only cell areas) without restrictions. The delegation can have access to all papers and files concerning the persons visited. The entire work of the Committee is based on confidentiality and cooperation.

40. After a visit, the Committee writes a report. Based on the facts observed during the visit, the report comments on the conditions found, makes concrete recommendations and asks any questions that need further clarification. The State party answers the report in writing and thereby establishes a dialogue between the Committee and the State party, which continues until the following visit. The Committee's reports and the State party's answers are confidential documents, but the State party (not the Committee) may decide to publish both the reports and the answers. So far, nearly all the States parties have made public both reports and answers.

41. In the course of its activities over the past ten years, the Committee has gradually developed a set of criteria for the treatment of persons held in custody that constitutes general standards. These standards deal not only with the material conditions but also with procedural safeguards. For example, three safeguards advocated by the Committee for persons held in police custody are:

(*a*) The right of a person deprived of liberty, if he or she so desires, to inform immediately a third party (family member) of the arrest;

(*b*) The right of a person deprived of liberty to have immediate access to a lawyer;

(*c*) The right of a person deprived of liberty to have access to a physician, including, if he or she so wishes, a physician of his or her own choice.

42. Furthermore, the Committee has stressed repeatedly that one of the most effective means of preventing ill-treatment by law enforcement officials lies in the diligent examination by competent authorities of all complaints of such treatment brought before them and, where appropriate, the imposition of a suitable penalty. This has a strong dissuasive effect.

[43] A person deprived of liberty is any person deprived of liberty by a public authority, such as, but not exclusively, persons arrested or in any form of detention, prisoners awaiting trial, sentenced prisoners and persons involuntarily confined to psychiatric hospitals.

4. *The African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights*

43. In comparison to the European and the Inter-American systems, Africa does not have a convention on torture and its prevention. The question of torture is examined on the same level as are other human rights violations. The question of torture is dealt with primarily in the African Charter of Human and Peoples' Rights, which was adopted by the Organization of African Unity on 27 June 1981 and which entered into force on 21 October 1986.[44] Article 5 of the African Charter states:

> Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

44. In accordance with article 30 of the African Charter, the African Commission on Human and Peoples' Rights was established in June 1987 and was charged "to promote human and peoples' rights and ensure their protection in Africa". In its periodic sessions, the Commission has passed several country resolutions on matters concerning human rights in Africa, some of which have dealt with torture, among other violations. In some of its country resolutions, the Commission raised concerns about the degradation of human rights situations, including the practice of torture.

45. The Commission has established new mechanisms, such as the Special Rapporteur on Prisons, the Special Rapporteur on Arbitrary and Summary Executions and the Special Rapporteur on Women, whose mandate is to report during the open sessions of the Commission. These mechanisms have created opportunities for victims and non-governmental organizations to send information directly to special rapporteurs. At the same time, a victim or a non-governmental organization can make a complaint to the Commission regarding acts of torture as defined in article 5 of the African Charter. While an individual complaint is pending before the Commission, the victim or the non-governmental organization can send the same information to special rapporteurs for their public reports to the Commission's sessions. To provide a forum for adjudicating claims of violations of the rights guaranteed in the African Charter, the Organization of African Unity Assembly adopted a protocol for the establishment of the African Court of Human and Peoples' Rights in June 1998.

D. The International Criminal Court

46. The Treaty of Rome, adopted on 17 July 1998, established the permanent International Criminal Court to try individuals responsible for genocide, crimes against humanity and war crimes. The court has jurisdiction over cases alleging torture either as part of the crime of genocide or as a crime against humanity, if the torture is committed "as part of a widespread or systematic attack", or as a war crime under the Geneva Conventions of 1949.

[44] OAU document CAB/LEG/67/3, rev. 5 (21 I.L.M. 58 (1982)).

CHAPTER II

RELEVANT ETHICAL CODES

47. All professions work within ethical codes, which provide a statement of the shared values and acknowledged duties of professionals and set moral standards with which they are expected to comply. Ethical standards are established primarily in two ways: by international instruments drawn up by bodies like the United Nations and by codes of principles drafted by the professions themselves, through their representative associations, nationally or internationally. The fundamental tenets are invariably the same and focus on obligations owed by the professional to individual clients or patients, to society at large and to colleagues in order to maintain the honour of the profession. These obligations reflect and complement the rights to which all people are entitled under international instruments.

A. Ethics of the legal profession

48. As the ultimate arbiters of justice, judges play a special role in the protection of the rights of citizens. International standards create an ethical duty on the part of judges to ensure that the rights of individuals are protected. Principle 6 of the United Nations Basic Principles on the Independence of the Judiciary states that "the principle of the independence of the judiciary entitles and requires the judiciary to ensure that judicial proceedings are conducted fairly and that the rights of the parties are respected".[45] Similarly, prosecutors have an ethical duty to investigate and prosecute a crime of torture committed by public officials. Article 15 of the United Nations Guidelines on the Role of Prosecutors states: "Prosecutors shall give due attention to the prosecution of crimes committed by public officials, particularly corruption, abuse of power, grave violations of human rights and other crimes recognized by international law and, where authorized by law or consistent with local practice, the investigation of such offences."[46]

49. International standards also establish a duty for lawyers, in carrying out their professional functions, to promote and protect human rights and fundamental freedoms. Principle 14 of the United Nations Basic Principles on the Role of Lawyers provides: "Lawyers, in protecting the rights of their clients and in promoting the cause of justice, shall seek to uphold human rights and fundamental freedoms recognized by national and international law and shall at all times act freely and diligently in accordance with the law and recognized standards and ethics of the legal profession."[47]

B. Health-care ethics

50. There are very clear links between concepts of human rights and the well-established principle of health-care ethics. The ethical obligations of health professionals are articulated at three levels and are reflected in United Nations documents in the same way as they are for the legal profession. They are also embodied in statements issued by international organizations representing health professionals, such as the World Medical Association, the World Psychiatric Association and the International Council of Nurses.[48] National medical associations and nursing organizations also issue codes of ethics, which their members are expected to follow. The central tenet of all health-care ethics, however articulated, is the fundamental duty always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations. In some countries, medical ethical principles, such as that of doctor-patient confidentiality, are incorporated into national law. Even where ethical principles are not established in law in this way, all health professionals are morally bound by the standards set by their professional bodies. They are judged to be guilty of misconduct if they deviate from professional standards without reasonable justification.

1. *United Nations statements relevant to health professionals*

51. Health professionals, like all other persons working in prison systems, must observe the Standard Minimum Rules for the Treatment of Prisoners, which require that medical, including psychiatric, services must be available to all prisoners without discrimination and that

[45] Adopted by the Seventh United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Milan from 26 August to 6 September 1985 and endorsed by General Assembly resolutions 40/32 of 29 November 1985 and 40/146 of 13 December 1985.

[46] Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Havana from 27 August to 7 September 1990.

[47] See footnote 46.

[48] There are also a number of regional groupings, such as the Commonwealth Medical Association and the International Conference of Islamic Medical Associations that issue important statements on medical ethics and human rights for their members.

C. Principles common to all codes of health-care ethics

56. The principle of professional independence requires health professionals always to concentrate on the core purpose of medicine, which is to alleviate suffering and distress and avoid harm, despite other pressures. Several other ethical principles are so fundamental that they are invariably found in all codes and ethical statements. The most basic are the injunctions to provide compassionate care, do no harm and to respect patients' rights. These are central requirements for all health professionals.

1. *The duty to provide compassionate care*

57. The duty to provide care is expressed in a variety of ways in national and international codes and declarations. One aspect of this duty is the medical duty to respond to those in medical need. This is reflected in the World Medical Association's International Code of Medical Ethics, which recognizes the moral obligation of doctors to provide emergency care as a humanitarian duty.[59] The duty to respond to need and suffering is echoed in traditional statements in virtually all cultures.

58. Underpinning much of modern medical ethics are the principles established in the earliest statements of professional values that require doctors to provide care even at some risk to themselves. For example, the Caraka Samhita, a Hindu code dating from the first century AD, instructs doctors to "endeavour for the relief of patients with all thy heart and soul; thou shall not desert or injure thy patient for the sake of thy life or living". Similar instructions were given in early Islamic codes and the modern Declaration of Kuwait requires doctors to focus on the needy, be they "near or far, virtuous or sinner, friend or enemy".

59. Western medical values have been dominated by the influence of the Hippocratic oath and similar pledges, such as the Prayer of Maimonides. The Hippocratic oath represents a solemn promise of solidarity with other doctors and a commitment to benefit and care for patients while avoiding harming them. It also contains a promise to maintain confidentiality. These four concepts are reflected in various forms in all modern professional codes of health-care ethics. The World Medical Association's Declaration of Geneva is a modern restatement of the Hippocratic values.[60] It is a promise in which doctors undertake to make the health of their patients their primary consideration and vow to devote themselves to the service of humanity with conscience and dignity.

60. Aspects of the duty to care are reflected in many of the World Medical Association's declarations, which make clear that doctors must always do what is best for the patient, including detainees and alleged criminals. This duty is often expressed through the notion of professional independence, requiring doctors to adhere to best medical practices despite any pressure that might be applied. The World Medical Association's International Code of Medical Ethics emphasizes doctors' duty to provide care "in full technical and moral independence, with compassion and respect for human dignity". It also stresses the duty to act only in the patient's interest and says that doctors owe their patients complete loyalty. The World Medical Association's Tokyo Declaration and Declaration on Physician Independence and Professional Freedom make unambiguously clear that doctors must insist on being free to act in patients' interests, regardless of other considerations, including the instructions of employers, prison authorities or security forces.[61] The latter declaration requires doctors to ensure that "they have the professional independence to represent and defend the health needs of patients against all who would deny or restrict needed care for those who are sick or injured". Similar principles are prescribed for nurses in the International Council of Nurses Code.

61. Another way in which duty to provide care is expressed by the World Medical Association is through its recognition of patient rights. Its Declaration of Lisbon on the Rights of Patients recognizes that every person is entitled, without discrimination, to appropriate health care and reiterates that doctors must always act in a patient's best interest.[62] Patients must be guaranteed autonomy and justice, according to the declaration, and both doctors and providers of medical care must uphold patient's rights. "Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or restore them." Individuals are entitled to appropriate health care, regardless of factors such as their ethnic origin, political beliefs, nationality, gender, religion or individual merit. People accused or convicted of crimes have an equal moral entitlement to appropriate medical and nursing care. The World Medical Association's Declaration of Lisbon emphasizes that the only acceptable criterion for discriminating between patients is that of the relative urgency of their medical need.

2. *Informed consent*

62. While the declarations reflecting a duty of care all emphasize an obligation to act in the best interests of the individual being examined or treated, this presupposes that health professionals know what is in the patient's best interest. An absolutely fundamental precept of modern medical ethics is that patients themselves are the best judge of their own interests. This requires health professionals to give normal precedence to a competent adult patient's wishes rather than to the views of any person in authority about what would be best for that individual. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgement about how that person's best interests can be protected and promoted. Nurses and doctors are expected to act as an advocate for their patients, and this is made clear in statements such as the World Medical Association's Declaration of Lisbon and the International Council of Nurses' statement on the Nurse's Role in Safeguarding Human Rights.[63]

[59] Adopted by the World Medical Association in 1949.

[60] Adopted by the World Medical Association in 1948.

[61] Adopted by the World Medical Association in 1986.

[62] Adopted by the World Medical Association in 1981; amended by the forty-seventh session of the General Assembly in September 1995.

[63] Adopted by the World Medical Association in 1983.

as failure to take an immediate stand makes protest at a later stage more difficult. They should report the matter to appropriate authorities or international agencies who can investigate, but without exposing patients, their families or themselves to foreseeable serious risk of harm. Doctors and professional associations should support colleagues who take such action on the basis of reasonable evidence.

2. *Dilemmas arising from dual obligations*

67. Dilemmas may occur when ethics and law are in contradiction. Circumstances can arise where their ethical duties oblige health professionals not to obey a particular law, such as a legal obligation to reveal confidential medical information about a patient. There is consensus in international and national declarations of ethical precepts that other imperatives, including the law, cannot oblige health professionals to act contrary to medical ethics and to their conscience. In such cases, health professionals must decline to comply with the law or a regulation rather than compromise basic ethical precepts or expose patients to serious danger.

68. In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which have an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaching the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters.

69. The ethical obligations of a doctor may vary according to the context of the doctor-patient encounter and the possibility of the patient being able to exercise free choice about the disclosure decision. For example, where the doctor and patient are in a clearly therapeutic situation, such as the provision of care in hospital, there is a strong moral imperative for doctors to preserve the usual rules of confidentiality that normally prevail in therapeutic relationships. Reporting evidence of torture obtained in such encounters is entirely appropriate as long as the patient does not forbid it. Doctors should report such evidence if patients request it or give properly informed consent to it. They should support patients in such decisions.

70. Forensic doctors have a different relationship with individuals they examine and usually have an obligation to report their observations factually. The patient has less power and choice in such situations and may not be able to speak openly about what has occurred. Before beginning any examination, forensic doctors must explain their role to the patient and make clear that medical confidentiality is not a usual part of their role, as it would be in a therapeutic context. Regulations may not permit the patient to refuse examination, but the patient has an option of choosing whether to disclose the cause of any injury. Forensic doctors should not falsify their reports but should provide impartial evidence, including making clear in their reports any evidence of maltreatment.[67]

71. Prison doctors are primarily providers of therapeutic treatment but they also have the task of examining detainees arriving in prison from police custody. In this role or in treatment of people within a prison, they may discover evidence of unacceptable violence, which prisoners themselves are not in a realistic position to denounce. In such situations, doctors must bear in mind the best interests of the patient and their duties of confidentiality to that person, but the moral arguments for the doctor to denounce evident maltreatment are strong, since prisoners themselves are often unable to do so effectively. Where prisoners agree to disclosure, no conflict arises and the moral obligation is clear. If a prisoner refuses to allow disclosure, doctors must weigh the risk and potential danger to that individual patient against the benefits to the general prison population and the interests of society in preventing the perpetuation of abuse.

72. Health professionals must also bear in mind that reporting abuse to the authorities in whose jurisdiction it is alleged to have occurred may well entail risks of harm for the patient or for others, including the whistle-blower. Doctors must not knowingly place individuals in danger of reprisal. They are not exempt from taking action but should use discretion and must consider reporting the information to a responsible body outside the immediate jurisdiction or, where this would not entail foreseeable risks to health professionals and patients, report it in a non-identifiable manner. Clearly, if the latter solution is taken, health professionals must take into account the likelihood of pressure being brought on them to disclose identifying data or the possibility of having their medical records forcibly seized. While there are no easy solutions, health professionals should be guided by the basic injunction to avoid harm above all other considerations and seek advice, where possible, from national or international medical bodies.

[67] See V. Iacopino et al., "Physician complicity in misrepresentation and omission of evidence of torture in post-detention medical examinations in Turkey", *Journal of the American Medical Association (JAMA)*, 276 1996:396-402.

the inquiry.[68] The persons conducting the investigation must have at their disposal all the necessary budgetary and technical resources for effective investigation. They also must have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill-treatment to appear and testify. The same applies to any witness. To this end, the investigative authority is entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence. Alleged victims of torture or ill-treatment, witnesses, those conducting the investigation and their families must be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment should be removed from any position of control or power, whether direct or indirect, over complainants, witnesses or their families, as well as those conducting the investigation.

80. Alleged victims of torture or ill-treatment and their legal representatives must be informed of, and have access to, any hearing as well as to all information relevant to the investigation and must be entitled to present other evidence.

81. In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States must ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission should be chosen for their recognized impartiality, competence and independence as individuals. In particular, they must be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission must have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these principles.[69] A written report, made within a reasonable time, must include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. On completion, this report must be made public. It must also describe in detail specific events that were found to have occurred, the evidence upon which such findings were based and list the names of witnesses who testified with the exception of those whose identities have been withheld for their own protection. The State must, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate steps to be taken in response.

82. Medical experts involved in the investigation of torture or ill-treatment should behave at all times in conformity with the highest ethical standards and, in particular, must obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations must be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials. The medical expert should promptly prepare an accurate written report. This report should include at least the following:

(*a*) The circumstances of the interview. The name of the subject and name and affiliation of those present at the examination; the exact time and date, location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house, etc.); any appropriate circumstances at the time of the examination (e.g. nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner, threatening statements to the examiner, etc.); and any other relevant factor;

(*b*) The background. A detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, the time when torture or ill-treatment was alleged to have occurred and all complaints of physical and psychological symptoms;

(*c*) A physical and psychological examination. A record of all physical and psychological findings upon clinical examination including appropriate diagnostic tests and, where possible, colour photographs of all injuries;

(*d*) An opinion. An interpretation as to the probable relationship of physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment or further examination should also be given;

(*e*) A record of authorship. The report should clearly identify those carrying out the examination and should be signed.

83. The report should be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process should be solicited and recorded in the report. The report should be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that the report is delivered securely to these persons. The report should not be made available to any other person, except with the consent of the subject or when authorized by a court empowered to enforce the transfer. For general considerations for written reports following allegations of torture see chapter IV. Chapters V and VI describe in detail the physical and psychological assessments, respectively.

C. Procedures of a torture investigation

1. *Determination of the appropriate investigative body*

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

[68] Under certain circumstances professional ethics may require information to be kept confidential. These requirements should be respected.

[69] See footnote 68.

according to the particular situation and purpose of the evaluation. Examples of various contexts include, but are not limited to, the following:

(i) In prison or detention in the individual's home country;

(ii) In prison or detention in another country;

(iii) Not in detention in the home country but in a hostile.oppressive climate;

(iv) Not in detention in the home country during a time of peace and security;

(v) In another country that may be friendly or hostile;

(vi) In a refugee camp setting;

(vii) In a war crimes tribunal or truth commission.

92. The political context may be hostile towards the victim and the examiner, for example, when detainees are interviewed while they are held in prison by their governments or while they are detained by foreign governments in order to be deported. In countries where asylum-seekers are examined in order to establish evidence of torture, the reluctance to acknowledge claims of trauma and torture may be politically motivated. The possibility of further endangering the safety of the detainee is very real and must be taken into account during every evaluation. Even in cases where persons alleging torture are not in imminent danger, investigators should use great care in their contact with them. The investigator's choice of language and attitude will greatly affect the alleged victim's ability and willingness to be interviewed. The location of the interview should be as safe and comfortable as possible, including access to toilet facilities and refreshments. Sufficient time should be allotted to interview the alleged torture victim. Investigators should not expect to get the full story during the first interview. Questions of a private nature will be traumatic for the alleged victim. The investigator must be sensitive in tone, phrasing and sequencing of questions, given the traumatic nature of the alleged victim's testimony. The witness must be told of the right to stop the questioning at any time, to take a break if needed or to choose not to respond to any question.

93. Psychological or counselling services trained in working with torture victims should be accessible, if possible, to the alleged torture victim, witnesses and members of the investigating team. Retelling the facts of the torture may cause the person to relive the experience or suffer other trauma-related symptoms (see chapter IV.H.). Hearing details of torture may result in secondary trauma symptoms to interviewers, and they must be encouraged to discuss their reactions with each other, respecting their professional ethical requirements of confidentiality. Wherever possible, this should be with the help of an experienced facilitator. There are two particular risks to be aware of: first, there is a danger that the interviewer may identify with those alleging torture and not be sufficiently challenging of the story; second, the interviewer may become so used to hearing histories of torture that he or she diminishes in his or her own mind the experiences of the person being interviewed.

(d) *Safety of witnesses*

94. The State is responsible for protecting alleged victims, witnesses and their families from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture should be removed from any position of control or power, whether direct or indirect over complainants, witnesses and their families as well as those conducting investigations. Investigators must give constant consideration to the effect of the investigation on the safety of the person alleging torture and other witnesses.

95. One suggested technique for providing a measure of safety to interviewees, including prisoners in countries in conflict situations, is to write down and keep safe the identities of people visited so that investigators can follow up on the safety of those individuals at a future return visit. Investigators must be allowed to talk to anyone and everyone, freely and in private, and be allowed to repeat the visit to these same persons (thus the need for traceable identities of those interviewed) as the need arises. Not all countries accept these conditions, and investigators may find it difficult to obtain similar guarantees. In cases in which witnesses are likely to be put in danger because of their testimony, the investigator should seek other forms of evidence.

96. Prisoners are in greater potential danger than persons who are not in custody. Prisoners might have different reactions to different situations. In one situation, prisoners may put themselves in danger unwittingly by speaking out too rashly, thinking they are protected by the very presence of the "outside" investigator. This may not be the case. In other situations, investigators may come up against a "wall of silence", as prisoners are far too intimidated to trust anyone, even when offered talks in private. In the latter case, it may be necessary to start with "group interviews", so as to be able to clearly explain the scope and purpose of the investigation and subsequently offer to have interviews in private with those persons who desire to speak. If the fear of reprisals, justified or not, is too great, it may be necessary to interview all prisoners in a given place of custody, so as not to pinpoint any specific person. Where an investigation leads to prosecution or another public truth-telling forum, the investigator should recommend measures to prevent harm to the alleged torture victim by such means as expunging names and other information that identifies the person from the public records or offering the person an opportunity to testify through image or voice-altering devices or closed circuit television. These measures must be consistent with the rights of the accused.

(e) *Use of interpreters*

97. Working through an interpreter when investigating torture is not easy, even with professionals. It will not always be possible to have interpreters on hand for all different dialects and languages, and sometimes it may be necessary to use interpreters from the person's family or cultural group. This is not ideal, as the person may not always feel comfortable talking about the torture experience through people he or she knows. Ideally, the interpreter should be part of the investigating team and knowl-

nel and other investigators should coordinate their efforts in carrying out a thorough investigation of the place where torture allegedly occurred. Investigators must have unrestricted access to the alleged scene of torture. Their access must include, but not be limited to, open or closed areas, including buildings, vehicles, offices, prison cells or other premises where torture is alleged to have taken place.

102. Any building or area under investigation must be closed off so as not to lose any possible evidence. Only investigators and their staff should be allowed entry into the area once it has been designated as under investigation. Examination of the scene for any material evidence should take place. All evidence must be properly collected, handled, packaged, labelled and placed in safekeeping to prevent contamination, tampering or loss of evidence. If the torture has allegedly taken place recently enough for such evidence to be relevant, any samples found of body fluids (such as blood or semen), hair, fibres and threads should be collected, labelled and properly preserved. Any implements that could be used to inflict torture, whether they be destined for that purpose or used circumstantially, should be taken and preserved. If recent enough to be relevant, any fingerprints located must be lifted and preserved. A labelled sketch of the premises or place where torture has allegedly taken place must be made to scale, showing all relevant details, such as the location of the floors in a building, rooms, entrances, windows, furniture and surrounding terrain. Colour photographs must also be taken to record the same. A record of the identity of all persons at the alleged torture scene must be made, including complete names, addresses and telephone numbers or other contact information. If torture is recent enough for it to be relevant, an inventory of the clothing of the person alleging torture should be taken and tested at a laboratory, if available, for bodily fluids and other physical evidence. Information must be obtained from anyone present in the premises or areas under investigation to determine whether they were witness to the incidents of alleged torture. Any relevant papers, records or documents should be saved for evidential use and handwriting analysis.

4. *Medical evidence*

103. The investigator should arrange for a medical examination of the alleged victim. The timeliness of such medical examination is particularly important. A medical examination should be undertaken regardless of the length of time since the torture, but if it is alleged to have happened within the past six weeks, such an examination should be arranged urgently before acute signs fade. The examination should include an assessment of the need for treatment of injuries and illnesses, psychological help, advice and follow-up (see chapter V for a description of the physical examination and forensic evaluation). A psychological evaluation and appraisal of the alleged torture victim is always necessary and may be part of the physical examination, or where there are no physical signs, may be performed by itself (see chapter VI for a description of the psychological evaluation).

104. In formulating a clinical impression for the purposes of reporting physical and psychological evidence of torture, there are six important questions to ask:

(*a*) Are the physical and psychological findings consistent with the alleged report of torture?

(*b*) What physical conditions contribute to the clinical picture?

(*c*) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

(*d*) Given the fluctuating course of trauma-related mental disorders over time, what is the time-frame in relation to the torture events? Where in the course of recovery is the individual?

(*e*) What other stressful factors are affecting the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.)? What impact do these issues have on the victim?

(*f*) Does the clinical picture suggest a false allegation of torture?

5. *Photography*

105. Colour photographs should be taken of the injuries of persons alleging that they have been tortured, of the premises where torture has allegedly occurred (interior and exterior) and of any other physical evidence found there. A measuring tape or some other means of showing scale on the photograph is essential. Photographs must be taken as soon as possible, even with a basic camera, because some physical signs fade rapidly and locations can be interfered with. Instantly-developed photos may decay over time. More professional photos are preferred and should be taken when the equipment becomes available. If possible, photographs should be taken using a 35-millimetre camera with an automatic date feature. The chain of custody of the film, negatives and prints must be fully documented.

D. Commission of inquiry

1. *Defining the scope of the inquiry*

106. States and organizations establishing commissions of inquiry need to define the scope of the inquiry by including terms of reference in their authorization. Defining the commission's terms of reference can greatly increase its success by giving legitimacy to the proceedings, assisting commission members in reaching a consensus on the scope of inquiry and providing a measure by which the commission's final report can be judged. Recommendations for defining terms of reference are as follows:

(*a*) They should be neutrally framed so that they do not suggest a predetermined outcome. To be neutral, terms of reference must not limit investigations in areas that might uncover State responsibility for torture;

8. *Receipt of evidence*

114. Commissions of inquiry should have the power to compel testimony and produce documents, plus the authority to compel testimony from officials allegedly involved in torture. Practically, this authority may involve the power to impose fines or sentences if government officials or other individuals refuse to comply. Commissions of inquiry should invite persons to testify or submit written statements as a first step in gathering evidence. Written statements may become an important source of evidence if their authors are afraid to testify, cannot travel to proceedings or are otherwise unavailable. Commissions of inquiry should review other proceedings that could provide relevant information.

9. *Rights of parties*

115. Those alleging that they have been tortured and their legal representatives should be informed of and have access to any hearing and all information relevant to the investigation and must be entitled to present evidence. This particular emphasis on the role of the survivor as a party to the proceedings reflects the especially important role their interests play in the conduct of the investigation. However, all other interested parties should also have an opportunity to be heard. The investigative body must be entitled to issue summons to witnesses, including the officials allegedly involved, and to demand the production of evidence. All these witnesses should be permitted legal counsel if they are likely to be harmed by the inquiry, for example, when their testimony could expose them to criminal charges or civil liability. Witnesses may not be compelled to testify against themselves. There should be an opportunity for the effective questioning of witnesses by the commission. Parties to the inquiry should be allowed to submit written questions to the commission.

10. *Evaluation of evidence*

116. The commission must assess all information and evidence it receives to determine reliability and probity. The commission should evaluate oral testimony, taking into account the demeanour and overall credibility of the witness. The commission must be sensitive to social, cultural and gender issues that affect demeanour. Corroboration of evidence from several sources will increase the probative value of such evidence and the reliability of hearsay evidence. The reliability of hearsay evidence must be considered carefully before the commission should accept it as fact. Testimony not tested by cross-examination must also be viewed with caution. In-camera testimony preserved in a closed record or not recorded at all is often not subject to cross-examination and, therefore, may be given less weight.

11. *Report of the commission*

117. The commission should issue a public report within a reasonable period of time. Furthermore, when the commission is not unanimous in its findings, the minority commissioners should file a dissenting opinion. Commission of inquiry reports should contain, at a minimum, the following information:

(*a*) The scope of inquiry and terms of reference;

(*b*) The procedures and methods of evaluating evidence;

(*c*) A list of all witnesses, including age and gender, who have testified, except for those whose identities are withheld for protection or who have testified in camera, and exhibits received as evidence;

(*d*) The time and place of each sitting (this might be annexed to the report);

(*e*) The background of the inquiry, such as relevant social, political and economic conditions;

(*f*) The specific events that occurred and the evidence upon which such findings are based;

(*g*) The law upon which the commission relied;

(*h*) The commission's conclusions based on applicable law and findings of fact;

(*i*) Recommendations based on the findings of the commission.

118. The State should reply publicly to the commission's report and, where appropriate, indicate which steps it intends to take in response to the report.

officials, should be available upon the medical examiner's request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient. Medical evaluation of detainees should be conducted at a location that the physician deems most suitable. In some cases, it may be best to insist on evaluation at official medical facilities and not at the prison or jail. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if they feel the medical premises may be under surveillance, for example. The best place will be dictated by many factors, but in all cases, investigators should ensure that prisoners are not forced into accepting a place they are not comfortable with.

124. The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the physician's official medical report. The presence of police officers, soldiers, prison officials or other law enforcement officials during the examination may be grounds for disregarding a negative medical report. The identity and titles of others who are present in the examination room during the medical evaluations should be indicated in the report. Medical-legal evaluations of detainees should include the use of a standardized medical report form (see annex IV for guidelines that may be used to develop standard medical report forms).

125. The original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor. When a detainee or a lawyer acting on his or her behalf requests a medical report, they must be provided with the report. Copies of all medical reports should be retained by the examining physician. A national medical association or a commission of inquiry may choose to audit medical reports to ensure that adequate procedural safeguards and documentation standards are adhered to, particularly by doctors employed by the State. Reports should be sent to such an organization, provided the issues of independence and confidentiality have been addressed. Under no circumstances should a copy of the medical report be transferred to law enforcement officials. It is mandatory that a detainee undergo a medical examination at the time of detention and an examination and evaluation upon release.[70] Access to a lawyer should be provided at the time of the medical examination. An outside presence during examination may be impossible in most prison situations. In such cases, it should be stipulated that prison doctors working with prisoners respect medical ethics, and they must be capable of carrying out their professional duties independently of any third party influence. If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee's legal disposition.[71]

[70] See the United Nations Standard Minimum Rules for the Treatment of Prisoners (chap. I.B.).

[71] Anonymous, "Health care for prisoners: implications of Kalk's refusal", *Lancet*, 1991 (337:647–648).

C. Official visits to detention centres

126. Visits to prisoners are not to be considered lightly. They can in some cases be notoriously difficult to carry out in an objective and professional way, particularly in countries where torture is still being practised. One-off visits, without follow-up to ensure the safety of the interviewees after the visit, may be dangerous. In some cases, one visit without a repeat visit may be worse than no visit at all. Well-meaning investigators may fall into the trap of visiting a prison or police station, without knowing exactly what they are doing. They may obtain an incomplete or false picture of reality. They may inadvertently place prisoners that they may never visit again in danger. They may give an alibi to the perpetrators of torture, who may use the fact that outsiders visited their prison and saw nothing.

127. Visits should best be left to investigators who can carry them out and follow them up in a professional way and who have certain weathered procedural safeguards for their work. The notion that some evidence is better than no evidence is not valid when working with prisoners who might be put in danger by giving testimony. Visits to detention facilities by well-meaning people representing official and non-governmental institutions can be difficult and, worse, can be counter-productive. In the case in point here, a distinction should be made between a bona fide visit necessary for the inquiry, which is not in question, and a non-essential visit that goes beyond that, which when done by non-specialists could cause more harm than good in a country that practises torture. Independent commissions constituted by jurists and physicians should be given ensured periodic access to visit places of detention and prisons.

128. Interviews with people who are still in custody, and possibly even in the hands of the perpetrators of torture obviously will be very different from interviews in the privacy and security of an outside and safe medical facility. The importance of obtaining the person's trust in such situations cannot be stressed enough. However, it is even more important not to, even unwittingly, betray that trust. All precautions should be taken so that detainees do not place themselves in danger. Detainees who have been tortured should be asked whether the information can be used and in what way. They may be too afraid to allow use of their names, for example fearing reprisals. Investigators, clinicians and interpreters are bound to respect what has been promised to the detainee.

129. A clear dilemma may arise if, for example, it is evident that a large number of prisoners have been tortured in a given place, but they all refuse to allow investigators to use their stories because of fear. Faced with the options of either betraying the prisoners' trust in the effort to stop torture or respecting trust and going away without saying anything, it will be necessary to find a useful way out of the dilemma. When confronted with a number of prisoners with clear signs on their bodies of whippings, beatings, lacerations caused by canings, etc., but who all refuse mention of their cases out of fear of reprisal, it is useful to organize a "health inspection" of the whole ward in full view in the courtyard. In that way, the visiting medical investigator walking through the ranks and

may be useful in piecing together the histories of different people. This will often prove very useful for the overall investigation.

3. *Circumstances of detention*

137. Consider the following questions: what time was it? Where were you? What were you doing? Who was there? Describe the appearance of those who detained you. Were they military or civilian, in uniform or in street clothes? What type of weapons were they carrying? What was said? Any witnesses? Was this a formal arrest, administrative detention or disappearance? Was violence used, threats spoken? Was there any interaction with family members? Note the use of restraints or blindfold, means of transportation, destination and names of officials, if known.

4. *Place and conditions of detention*

138. Include access to and descriptions of food and drink, toilet facilities, lighting, temperature and ventilation. Also, document any contact with family, lawyers or health professionals, conditions of overcrowding or solitary confinement, dimensions of the detention place and whether there are other people who can corroborate the detention. Consider the following questions: what happened first? Where were you taken? Was there an identification process (personal information recorded, fingerprints, photographs)? Were you asked to sign anything? Describe the conditions of the cell or room (note size, others present, light, ventilation, temperature, presence of insects, rodents, bedding and access to food, water and toilet). What did you hear, see and smell? Did you have any contact with people outside or access to medical care? What was the physical layout of the place where you were detained?

5. *Methods of torture and ill-treatment*

139. In obtaining background information on torture and ill-treatment, one should be cautious about suggesting forms of abuse that a person may have been subjected to. This may help separate potential embellishment from valid experiences. However, eliciting negative responses to questions about various forms of torture may also help establish the credibility of the person. Questions should be designed to elicit a coherent narrative account. Consider the following questions. Where did the abuse take place, when and for how long? Were you blindfolded? Before discussing forms of abuse, note who was present (give names, positions). Describe the room or place. Which objects did you observe? If possible, describe each instrument of torture in detail; for electrical torture, the current, device, number and shape of electrodes. Ask about clothing, disrobing and change of clothing. Record quotations of what was said during interrogation, insults to one's identity, etc. What was said among the perpetrators?

140. For each form of abuse note: body position, restraint, nature of contact, including duration, frequency, anatomical location and the area of the body affected. Was there any bleeding, head trauma or loss of consciousness? Was the loss of consciousness due to head trauma, asphyxiation or pain. One should also ask about how the person was at the end of the "session". Could he or she walk? Did she or he have to be helped or carried back to the cell? Could he or she get up the next day? How long did the feet stay swollen? All this gives a certain completeness to the description, which a checklist of methods does not. The history should include the date of positional torture, how many times and for how many days the torture lasted, the period of each episode, the style of the suspension (reverse-linear, being covered by thick cloth-blanket or being tied directly by a rope, putting weight on the legs or pulling down) or position. In cases of suspension torture, ask which sort of material was used (rope, wire and cloth leave different marks, if any, on the skin after suspension). The examiner must remember that statements of the length of the torture session by the torture survivor are subjective and may not be correct, since disorientation of time and place during torture is a generally observed finding. Was the person sexually assaulted in any manner? Elicit what was said during the torture. For example, during electric shock torture to the genitals perpetrators often tell their torture victims that they will no longer have normal sexual function or something similar. For a detailed discussion of the assessment of an allegation of sexual torture, including rape see chapter V.D.8.

F. Assessment of the background

141. Torture survivors may have difficulty recounting the specific details of the torture for several important reasons, including:

(*a*) Factors during torture itself, such as blindfolding, drugging, lapses of consciousness, etc.;

(*b*) Fear of placing oneself or others at risk;

(*c*) A lack of trust in the examining clinician or interpreter;

(*d*) The psychological impact of torture and trauma, such as high emotional arousal and impaired memory secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder;

(*e*) Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning or starvation;

(*f*) Protective coping mechanisms, such as denial and avoidance;

(*g*) Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.[72]

142. Inconsistencies in a person's story may arise from any or all of these factors. If possible, the investiga-

[72] R. F. Mollica and Y. Caspi-Yavin, "Overview: the assessment and diagnosis of torture events and symptoms", *Torture and Its Consequences, Current Treatment Approaches*, M. Baío», ed. (Cambridge, Cambridge University Press, 1992:38-55).

about the laboratory methods play a significant role (see chapter VI.B.2.(a)).

146. The presence of psychological sequelae in torture survivors, particularly the various manifestations of post-traumatic stress disorder, may cause the torture survivor to fear experiencing a re-enactment of his or her torture experience during the interview, physical examination or laboratory studies. Explaining to the torture survivor what he or she should expect prior to the medical examination is an important component of the process. Those who survive torture and remain in their country may experience intense fear and suspicion about being re-arrested, and they are often forced to go underground to avoid being arrested again. Those who are exiled or refugees may leave behind their native language, culture, family, friends, work and everything that is familiar to them.

147. The torture survivor's personal reactions to the interviewer (and the interpreter, in cases where one is used) can have an effect on the interview process and, in turn, the outcome of the investigation. Likewise, the personal reactions of the investigator towards the person can also affect the process of the interview and outcome of the investigation. It is important to examine the barriers to effective communication and understanding that these personal reactions might impose on an investigation. The investigator should maintain an ongoing examination of the process of the interviews and investigation through consultation and discussion with colleagues familiar with the field of psychological assessment and treatment of torture survivors. This type of peer supervision can be an effective means of monitoring the interview and investigation process for biases and barriers to effective communication and obtaining accurate information (see chapter VI.C.2.).

148. Despite all precautions, physical and psychological examinations by their very nature may re-traumatize the patient by provoking or exacerbating symptoms of post-traumatic stress by eliciting painful effects and memories (see chapter VI.B.2.). Questions about psychological distress and, especially, about sexual matters are considered taboo in most traditional societies, and the asking of such questions is regarded as irreverent or insulting. If sexual torture was part of the violations incurred, the claimant may feel irredeemably stigmatized and tainted in his or her moral, religious, social or psychological integrity. The expression of one's respectful awareness of these conditions, as well as the clarification of confidentiality and its limits, are, therefore, of paramount importance for a well-conducted interview. A subjective assessment has to be made by the evaluator about the extent to which pressing for details is necessary for the effectiveness of the report in court, especially if the claimant demonstrates obvious signs of distress in the interview.

I. Use of interpreters

149. For many purposes, it is necessary to use an interpreter to allow the interviewer to understand what is being said. Although the interviewer and the interviewee may share a little of a common language, the information being sought is often too important to risk the errors that come from incomplete understanding of each other. Interpreters must be advised that what they hear and interpret in interviews is strictly confidential. It is the interpreters who get all the information, first-hand and uncensored. Individuals must be given assurances that neither the investigator nor the interpreter will misuse information in any way (see chapter VI.C.2.).

150. When the interpreter is not a professional, there is always the risk of the investigator losing control of the interview. Individuals may be carried away talking to the person who speaks their language, and the interview may divert from the issues at hand. There is also a risk that an interpreter with a bias might lead the interviewee or distort the replies. Loss of information, sometimes relevant, sometimes not, is inevitable when working through interpretation. In extreme cases, it may even be necessary for investigators to refrain from taking notes during interviews and carry out interviews in several short sessions, so as to have time to write down the main points of what has been said between sessions.

151. Investigators should remember to talk to the person and to maintain eye contact, even if he or she has a natural tendency to speak to the interpreter. It helps to use the second person when speaking through the interpreter, for example "what did you do next", rather than the third person "ask him what happened next". All too often, investigators write their notes during the time when either the interpreter is translating the question or the interviewee is answering it. Some investigators do not appear to be listening, as the interview is going on in a language they do not understand. This should not be the case, as it is essential that investigators observe not just the words but also the body language, facial expressions, tone of voice and gestures of the interviewee if they are to get a full picture. Investigators should familiarize themselves with torture-related words in the person's language so as to show that they know about the issue. Reacting, rather than showing a blank face, when hearing a torture-related word such as *submarino* or *darmashakra* will add to the investigator's credibility.

152. When visiting prisoners, it is best never to use local interpreters if there is a possibility of their being considered untrustworthy by those interviewed. It may also be unfair to the local interpreters, who may be "debriefed" by the local authorities after a visit, or otherwise put under pressure, to involve them with political prisoners. It is best to use independent interpreters, clearly seen as coming from elsewhere. The next best thing to speaking the local language fluently is to work with a trained and clever interpreter, who is sensitive to the issue of torture and to the local culture. As a rule, co-detainees should not be used for interpretation, unless it is obvious that the interviewee has chosen someone he or she trusts. In the case of people who are not in detention, many of these same rules will also apply, but it may be easier to bring in someone (a local person) from the outside, which is rarely possible in prison situations.

CHAPTER V

PHYSICAL EVIDENCE OF TORTURE

160. Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person was tortured. However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars.

161. A medical evaluation for legal purposes should be conducted with objectivity and impartiality. The evaluation should be based on the physician's clinical expertise and professional experience. The ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. When possible, clinicians who conduct evaluations of detainees should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse. They should have knowledge of prison conditions and torture methods used in the particular region where the patient was imprisoned and the common after-effects of torture. The medical report should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons. The physician should not assume that the official requesting a medical-legal evaluation has related all the material facts. It is the physician's responsibility to discover and report upon any material findings that he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill-treatment must not be excluded from a medical-legal report under any circumstance.

A. Interview structure

162. These comments apply especially to interviews conducted with persons no longer in custody. The location of the interview and examination should be as safe and comfortable as possible. Sufficient time should be allotted to conduct a detailed interview and examination. A two-to-four hour interview may be insufficient to conduct an evaluation for physical or psychological evidence of torture. Furthermore, at any given time of an evaluation, situation-specific variables, such as the dynamics of the interview, feelings of powerlessness in the face of having one's intimacy intruded upon, fear of future persecution, shame about events and survivor guilt may simulate the circumstances of a torture experience. This may increase the patient's anxiety and resistance to disclose relevant information. A second, and possibly a third, interview may be needed to be scheduled to complete the evaluation.

163. Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of someone who has experienced torture or other forms of abuse requires active listening, meticulous communication, courtesy and genuine empathy and honesty. Physicians must have the capacity to create a climate of trust in which disclosure of crucial, though perhaps very painful or shameful, facts can occur. It is important to be aware that those facts are sometimes intimate secrets that the person may reveal at that moment for the first time. In addition to providing a comfortable setting, adequate time for the interviews, refreshments and access to toilet facilities, the clinicians should explain what the patient can expect in the evaluation. The clinician should be mindful of the tone, phrasing and sequencing of questions (sensitive questions should be asked only after some degree of rapport has been developed) and should acknowledge the patient's ability to take a break if needed or to choose not to respond to any question.

164. Physicians and interpreters have a duty to maintain confidentiality of information and to disclose information only with the patient's consent (see chapter III.C.). Each person should be examined individually with privacy. He or she should be informed of any limits on the confidentiality of the evaluation that may be imposed by State or judicial authorities. The purpose of the interview needs to be made clear to the person. Physicians must ensure that informed consent is based on adequate disclosure and understanding of the potential benefits and adverse consequences of a medical evaluation and that consent is given voluntarily without coercion by others, particularly law enforcement or judicial authorities. The person has the right to refuse the evaluation. In such circumstances, the clinician should document the reason for refusal of an evaluation. Furthermore, if the person is a detainee, the report should be signed by his or her lawyer and another health official.

165. Patients may fear that information revealed in the context of an evaluation cannot be safely kept from being accessed by persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture. In many circumstances, the evaluator will be a member of the majority culture and ethnicity, whereas the patient, in the situation and location of the interview, is likely to belong to a minority group or culture. This dynamic of inequality may reinforce the perceived and real imbalance of power and may increase the potential

so that any identified need can be followed up. In many situations, certain diagnostic test techniques will not be available, and their absence must not invalidate the report (see annex II for further details of possible diagnostic tests).

174. In cases of alleged recent torture and when the clothes worn during torture are still being worn by the torture survivor, they should be taken for examination without washing, and a fresh set of clothes should be provided. Wherever possible, the examination room should be equipped with sufficient illumination and medical equipment for the examination. Any deficiencies should be noted in the report. The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and nature of all injuries (see annex III). Some forms of torture such as electrical shock or blunt trauma may be initially undetectable, but may be detected during a follow-up examination. Although it will rarely be possible to record photographically lesions of prisoners in custody of their torturers, photography should be a routine part of examinations. If a camera is available, it is always better to take poor quality photographs than to have none. They should be followed up with professional photographs as soon as possible (see chapter III.C.5.).

1. *Skin*

175. The examination should include the entire body surface to detect signs of generalized skin disease including signs of vitamin A, B and C deficiency, pre-torture lesions or lesions inflicted by torture, such as abrasions, contusions, lacerations, puncture wounds, burns from cigarettes or heated instruments, electrical injuries, alopecia and nail removal. Torture lesions should be described by their localization, symmetry, shape, size, colour and surface (e.g. scaly, crusty, ulcerating) as well as their demarcation and level in relation to the surrounding skin. Photography is essential whenever possible. Ultimately, the examiner must offer an opinion as to the origin of the lesions: inflicted or self-inflicted, accidental or the result of a disease process.[73,74]

2. *Face*

176. Facial tissues should be palpated for evidence of fracture, crepitation, swelling or pain. The motor and sensory components, including smell and taste of all cranial nerves, should be examined. Computerized tomography (CT), rather than routine radiography, is the best modality to diagnose and characterize facial fractures, determine alignment and diagnose associated soft tissue injuries and complications. Intracranial and cervical spinal injuries are often associated with facial trauma.

[73] O.V. Rasmussen, "Medical aspects of torture", *Danish Medical Bulletin* (1990, 37 Supp. 1:1-88).

[74] R. Bunting, "Clinical examinations in the police context", *Clinical Forensic Medicine*, W.D.S. McLay, ed. (London, Greenwich Medical Media, 1996:59-73).

(a) *Eyes*

177. There are many forms of trauma to the eyes, including conjunctival haemorrhage, lens dislocation, subhyeloid haemorrhage, retrobulbar haemorrhage, retinal haemorrhage and visual field loss. Given the serious consequences of lack of treatment or improper treatment, ophthalmologic consultation should be obtained whenever there is a suspicion of ocular trauma or disease. Computerized tomography is the best modality to diagnose orbital fractures and soft tissue injuries to the bulbar and retrobulbar contents. Nuclear magnetic resonance imaging (MRI) may be an adjunct for identifying soft tissue injury. High resolution ultrasound is an alternative method for evaluation of trauma to the eye globe.

(b) *Ears*

178. Trauma to the ears, especially rupture of the tympanic membrane, is a frequent consequence of harsh beatings. The ear canals and tympanic membranes should be examined with an otoscope and injuries described. A common form of torture, known in Latin America as *telefono*, is a hard slap of the palm to one or both ears, rapidly increasing pressure in the ear canal, thus rupturing the drum. Prompt examination is necessary to detect tympanic membrane ruptures less than 2 millimetres in diameter, which may heal within 10 days. Fluid may be observed in the middle or external ear. If otorrhea is confirmed by laboratory analysis, magnetic resonance imaging or computerized tomography should be performed to determine the fracture site. The presence of hearing loss should be investigated, using simple screening methods. If necessary, audiometric tests should be conducted by a qualified audiometric technician. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain is best determined by computerized tomography, then hypocycloidal tomography and, lastly, linear tomography.

(c) *Nose*

179. The nose should be evaluated for alignment, crepitation and deviation of the nasal septum. For simple nasal fractures, standard nasal radiographs should be sufficient. For complex nasal fractures and when the cartilaginous septum is displaced, a computerized tomography should be performed. If rhinorrhea is present, computerized tomography or magnetic resonance imaging is recommended.

(d) *Jaw, oropharynx and neck*

180. Mandibular fractures or dislocations may result from beatings. Temporomandibular joint syndrome is a frequent consequence of beatings about the lower face and jaw. The patient should be examined for evidence of crepitation of the hyoid bone or laryngeal cartilage resulting from blows to the neck. Findings concerning the oropharynx should be noted in detail, including lesions consistent with burns from electrical shock or other trauma. Gingival haemorrhage and the condition of the gums should also be noted.

(*b*) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes;

(*c*) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes;

(*d*) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes;

(*e*) Diagnostic of: this appearance could not have been caused in any way other than that described.

187. Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story (see chapter IV.G. for a list of torture methods).

1. *Beatings and other forms of blunt trauma*

(a) *Skin damage*

188. Acute lesions are often characteristic of torture, because they show a pattern of inflicted injury that differs from non-inflicted injuries, for example, their shape, repetition, distribution on the body. Since most lesions heal within about six weeks of torture, leaving no scars or non-specific scars, a characteristic history of the acute lesions and their development until healing might be the only support of an allegation of torture. Permanent changes in the skin due to blunt trauma are infrequent, non-specific and usually without diagnostic significance. A sequel of blunt violence, which is diagnostic of prolonged application of tight ligatures, is a linear zone extending circularly around the arm or leg, usually at the wrist or ankle. This zone contains few hairs or hair follicles, and this is probably a form of cicatricial alopecia. No differential diagnosis in the form of a spontaneous skin disease exists, and it is difficult to imagine any trauma of this nature occurring in everyday life.

189. Among acute lesions, abrasions resulting from superficial scraping lesions of the skin may appear as scratches, brush-burn type lesions or larger scraped lesions. At times, abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Repeated or deep abrasions may create areas of hypo or hyperpigmentation, depending on skin type. This occurs on the inside of the wrists if the hands have been tied together tightly.

190. Contusions and bruises are areas of haemorrhage into soft tissue due to the rupture of blood vessels from blunt trauma. The extent and severity of a contusion depend not only on the amount of force applied but also on the structure and vascularity of the contused tissue. Contusions occur more readily in areas of thin skin overlying bone or in fatty areas. Many medical conditions, including vitamin and other nutritional deficiencies, may be associated with easy bruising or purpura. Contusions and abrasions indicate that blunt force has been applied to a particular area. The absence of a bruise or abrasion, however, does not indicate that there was no blunt force to that area. Contusions may be patterned, reflecting the contours of the inflicting instrument. For instance, rail-shaped bruising may occur when an instrument, such as a truncheon or cane, has been used. The shape of the object may be inferred from the shape of the bruise. As contusions resolve, they undergo a series of colour changes. Most bruises initially appear dark blue, purple or crimson. As the haemoglobin in the bruise breaks down, the colour gradually changes to violet, green, dark yellow or pale yellow and then disappears. It is very difficult, however, to date accurately the occurrence of contusions. In some skin types, this can lead to hyperpigmentation, which can last several years. Contusions that develop in deeper subcutaneous tissues may not appear until several days after injury, when the extravasated blood has reached the surface. In cases of an allegation but an absence of a contusion, the victim should be re-examined after several days. It should be taken into consideration that the final position and shape of bruises bear no relationship to the original trauma and that some lesions may have faded by the time of re-examination.[78]

191. Lacerations, a tearing or crushing of the skin and underlying soft tissues by the pressure of blunt force, develop easily on the protruding parts of the body, since the skin is compressed between the blunt object and the bone surface under the subdermal tissues. However, with sufficient force the skin can be torn on any part of the body. Asymmetrical scars, scars in unusual locations and a diffuse spread of scarring all suggest deliberate injury.[79]

192. Scars resulting from whipping represent healed lacerations. These scars are depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes. The only differential diagnosis is plant dermatitis, but this is dominated by hyperpigmentation and shorter scars. By contrast, symmetrical, atrophic, depigmented linear changes of the abdomen, axillae and legs, which are sometimes claimed to be torture sequelae, represent striae distensae and are not normally related to torture.[80]

193. Burning is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, these changes may be of diagnostic value. Cigarette burns often leave 5-10-millimetre-long, circular or ovoid, macular scars with a hyper or a hypopigmented centre and a hyperpigmented, relatively indistinct periphery. The burning away of tattoos with cigarettes has also been reported in relation to torture. The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis.[81] Burning with hot objects produces markedly atrophic scars which reflect the shape of the instrument and which are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation. This may, for instance, be seen after burning with an electrically

[78] S. Gürpinar and S. Korur Fincanci, "*Insan Haklari Ihlalleri ve Hekim Sorumlulugu*" (Human Rights Violations and Responsibility of the Physician), *Birinci Basamak İçin Adli Tip El Kitabi* (Handbook of Forensic Medicine for General Practitioners) (Ankara, Turkish Medical Association, 1999).

[79] O.V. Rasmussen, "Medical aspects of torture", *Danish Medical Bulletin* (37 Supp. 1 1990:1-88).

[80] L. Danielsen, "Skin changes after torture", *Torture* (Supp. 1, 1992:27-28).

[81] See footnote 80.

2. *Beatings of the feet*

202. *Falanga* is the most common term for repeated application of blunt trauma to the feet (or more rarely to the hands or hips), usually applied with a truncheon, length of pipe or similar weapon. The most severe complication of *falanga* is closed compartment syndrome, which can cause muscle necrosis, vascular obstruction or gangrene of the distal portion of the foot or toes. Permanent deformities of the feet are uncommon but do occur, as do fractures of the carpal, metacarpal and phalanges. Because the injuries are usually confined to soft tissue, computerized tomography or magnetic resonance imaging are the preferred methods for radiological documentation of the injury, but it must be emphasized that physical examination in the acute phase should be diagnostic. *Falanga* may produce chronic disability. Walking may be painful and difficult. The tarsal bones may be fixed (spastic) or have increased motion. Squeezing the plantar (sole) of the foot and dorsiflexion of the great toe may produce pain. On palpation, the entire length of the plantar aponeurosis may be tender and the distal attachments of the aponeurosis may be torn, partly at the base of the proximal phalanges, partly at the skin. The aponeurosis will not tighten normally, making walking difficult and muscle fatigue may follow. Passive extension of the big toe may reveal whether the aponeurosis has been torn. If it is intact, one should feel the beginning of tension in the aponeurosis on palpation when the toe is dorsiflexed to 20 degrees; maximum normal extension is about 70 degrees. Higher values suggest injury to the attachments of the aponeurosis.[83,84,85,86] On the other hand, limited dorsiflexion and pain on hyperextension of the large toe are findings of *hallux rigidus*, which results from dorsal osteophyte at either or both of the first metatarsal head or base of the proximal phalanx.

203. Numerous complications and syndromes can occur:

(*a*) Closed compartment syndrome. This is the most severe complication. An oedema in a closed compartment results in vascular obstruction and muscle necrosis, which may result in fibrosis, contracture or gangrene in the distal foot or toes. It is usually diagnosed by measuring pressures in the compartment;

(*b*) Crushed heel and anterior footpads. The elastic pads under the calcaneus and proximal phalanxes are crushed during *falanga*, either directly or as a result of oedema associated with the trauma. Also, the connective tissue bands that extend through adipose tissue and connect bone to the skin are torn. Adipose tissue is deprived of its blood supply and atrophies. The cushioning effect is lost and the feet no longer absorb the stresses produced by walking;

(*c*) Rigid and irregular scars involving the skin and subcutaneous tissues of the foot after the application of *falanga*. In a normal foot, the dermal and sub-dermal tissues are connected to the planter aponeurosis through tight connective tissue bands. However, these bands can be partially or completely destroyed due to the oedema that ruptures the bands after exposure to *falanga*;

(*d*) Rupture of the plantar aponeurosis and tendons of the foot. An oedema in the post-*falanga* period may rupture these structures. When the supportive function necessary for the arch of the foot disappears, the act of walking becomes more difficult and foot muscles, especially the *quadratus plantaris longus*, are excessively forced;

(*e*) Planter fasciitis. May occur as a further complication of this injury. In cases of *falanga*, irritation is often present throughout the whole aponeurosis, causing chronic aponeurositis. In studies on the subject, prisoners released after 15 years of detention and who claimed to have been subjected to *falanga* application when first arrested, positive bone scans of hyperactive points in the calcaneus or metatarsal bones were observed.[87]

204. Radiological methods such as magnetic resonance imaging, computerized tomography scan and ultrasound can often confirm cases of trauma occurring as a result of the application of *falanga*. Positive radiological findings may also be secondary to other diseases or trauma. Routine radiographs are recommended as the initial examination. Magnetic resonance imaging is the preferred radiological examination to detect soft tissue injury. Magnetic resonance imaging or scintigraphy may detect bone injury in the form of a bruise, which may not be detected by routine radiographs or computerized tomography.[88]

3. *Suspension*

205. Suspension is a common form of torture that can produce extreme pain, but which leaves little, if any, visible evidence of injury. A person still in custody may be reluctant to admit to being tortured, but the finding of peripheral neurological deficits, diagnostic of brachial plexopathy, virtually proves the diagnosis of suspension torture. Suspension can be applied in various forms:

(*a*) Cross suspension. Applied by spreading the arms and tying them to a horizontal bar;

(*b*) Butchery suspension. Applied by fixation of hands upwards, either together or one by one;

(*c*) Reverse butchery suspension. Applied by fixation of feet upward and the head downward;

(*d*) "Palestinian" suspension. Applied by suspending the victim with the forearms bound together behind the back, the elbows flexed 90 degrees and the forearms tied

[83] G. Sklyv, "Physical sequelae of torture", *Torture and its consequences, current treatment approaches*, M. Baloılu ed. (Cambridge, Cambridge University Press, 1992:38-55).

[84] D. Forrest, "Examination for the late physical after effects of torture", *Journal of Clinical Forensic Medicine* (6 1999:4-13).

[85] K. Prip, L. Tived, N. Holten, *Physiotherapy for Torture Survivors: A Basic Introduction* (Copenhagen, IRCT, 1995).

[86] F. Bojsen-Moller and K.E. Flagstad, "Plantar aponeurosis and plantar architecture of the ball of the foot", *Journal of Anatomy* (121 1976:599-611).

[87] V. Lök, M. Tunca, K. Kumanlioglu et al., "Bone scintigraphy as clue to previous torture", *Lancet* (337(8745) 1991:846–847). See also M. Tunca and V. Lök, "Bone scintigraphy in screening of torture survivors", *Lancet* (352(9143) 1998:1859).

[88] See references 82 and 83 and V. Lök et al., "Bone scintigraphy as an evidence of previous torture, *Treatment and Rehabilitation Center Report of HRFT* (Ankara, 1994:91-96).

hand-cranked or combustion generator, wall source, stun gun, cattle prod or other electric device. Electric current follows the shortest route between the two electrodes. The symptoms that occur when electric current is applied have this characteristic. For example, if electrodes are placed on a toe of the right foot and on the genital region, there will be pain, muscle contraction and cramps in the right thigh and calf muscles. Excruciating pain will be felt in the genital region. Since all muscles along the route of the electric current are tetanically contracted, dislocation of the shoulder, lumbar and cervical radiculopathies may be observed when the current is moderately high. However, the type, time of application, current and voltage of the energy used cannot be determined with certainty upon physical examination of the victim. Torturers often use water or gels in order to increase the efficiency of the torture, expand the entrance point of the electric current on the body and prevent detectable electric burns. Trace electrical burns are usually a reddish brown circular lesion from 1 to 3 millimetres in diameter, usually without inflammation, which may result in a hyperpigmented scar. Skin surfaces must be carefully examined because the lesions are often not easily discernible. The decision to biopsy recent lesions to prove their origin is controversial. Electrical burns may produce specific histologic changes, but these are not always present, and the absence of change in no way mitigates against the lesion being an electrical burn. The decision must be made on a case-by-case basis as to whether or not the pain and discomfort associated with a skin biopsy can be justified by the potential results of the procedure (see annex II.2.).

6. *Dental torture*

212. Dental torture may be in the form of breaking, extraction of teeth or through application of electrical current to the teeth. It may result in a loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement and, in some cases, subluxation of this joint due to muscle spasms occurring as a result of the electrical current or blows to the face.

7. *Asphyxiation*

213. Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no mark, and recuperation is rapid. This method of torture was so widely used in Latin America, that its name in Spanish, *submarino*, became part of human rights vocabulary. Normal respiration might be prevented through methods such as covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or forced aspiration of dust, cement, hot peppers, etc. This is also known as "dry *submarino*". Various complications might develop, such as petechiae of the skin, nosebleeds, bleeding from the ears, congestion of the face, infections in the mouth and acute or chronic respiratory problems. Forcible immersion of the head in water, often contaminated with urine, faeces, vomit or other impurities, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is called "wet *submarino*". In hanging or in other ligature asphyxiation, patterned abrasions or contusions can often be found on the neck. The hyoid bone and laryngeal cartilage may be fractured by partial strangulation or from blows to the neck.

8. *Sexual torture including rape*

214. Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. One is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the background of potential abuse, rape or sodomy. Furthermore, verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects, all part and parcel of the procedure. The groping of women is traumatic in all cases and is considered to be torture.

215. There are some differences between sexual torture of men and sexual torture of women, but several issues apply to both. Rape is always associated with the risk of developing sexually transmitted diseases, particularly human immunodeficiency virus (HIV).[89] Currently, the only effective prophylaxis against HIV must be taken within hours of the incident, and it is not generally available in countries where torture occurs routinely. In most cases, there will be a lewd sexual component, and in other cases torture is targeted at the genitals. Electricity and blows are generally targeted on the genitals in men, with or without additional anal torture. The resulting physical trauma is enhanced by verbal abuse. There are often threats of loss of masculinity to men and consequent loss of respect in society. Prisoners may be placed naked in cells with family members, friends or total strangers, breaking cultural taboos. This can be made worse by the absence of privacy when using toilet facilities. Additionally, prisoners may be forced to abuse each other sexually, which can be particularly difficult to cope with emotionally. The fear of potential rape among women, given profound cultural stigma associated with rape, can add to the trauma. Not to be neglected are the trauma of potential pregnancy, which males, obviously, do not experience, the fear of losing virginity and the fear of not being able to have children (even if the rape can be hidden from a potential husband and the rest of society).

216. If in cases of sexual abuse the victim does not wish the event to be known due to sociocultural pressures or personal reasons, the physician who carries out the medical examination, investigative agencies and the courts have an obligation to cooperate in maintaining the victim's privacy. Establishing a rapport with torture survivors who have been recently sexually assaulted requires special psychological education and appropriate psychological support. Any treatment that would increase the psychological trauma of a torture survivor should be avoided. Before starting the examination, permission must be obtained from the individual for any kind of

[89] D. Lunde and J. Ortmann, "Sexual torture and the treatment of its consequences, *Torture and its consequences, current treatment approaches*, M. Baĭo»lu, ed. (Cambridge, Cambridge University Press, 1992:310-331).

some time before the individual is willing to discuss those aspects of the torture that he or she finds most embarrassing. Similarly, patients may wish to postpone the more intimate parts of the examination to a subsequent consultation, if time and circumstances permit.

(d) *Follow-up*

224. Many infectious diseases can be transmitted by sexual assault, including sexually transmitted diseases such as gonorrhoea, chlamydia, syphilis, HIV, hepatitis B and C, herpes simplex and *condyloma acuminatum* (venereal warts), vulvovaginitis associated with sexual abuse, such as trichomonas, *moniliasis vaginitis*, *gardenarella vaginitis* and *enterobius vermicularis* (pinworms), as well as urinary tract infections.

225. Appropriate laboratory tests and treatment should be prescribed in all cases of sexual abuse. In the case of gonorrhoea and chlamydia, concomitant infection of the anus or oropharynx should be considered at least for examination purposes. Initial cultures and serologic tests should be obtained in cases of sexual assault, and appropriate therapy initiated. Sexual dysfunction is common among survivors of torture, particularly among victims who have suffered sexual torture or rape, but not exclusively. Symptoms may be physical or psychological in origin or a combination of both and include:

(i) Aversion to members of the opposite sex or decreased interest in sexual activity;

(ii) Fear of sexual activity because a sexual partner will know that the victim has been sexually abused or fear of having been damaged sexually. Torturers may have threatened this and instilled fear of homosexuality in men who have been anally abused. Some heterosexual men have had an erection and, on occasion, have ejaculated during non-consensual anal intercourse. They should be reassured that this is a physiological response;

(iii) Inability to trust a sexual partner;

(iv) Disturbance in sexual arousal and erectile dysfunction;

(v) Dyspareunia (painful sexual intercourse in females) or infertility due to acquired sexually transmitted disease, direct trauma to reproductive organs or poorly performed abortions of pregnancies following rape.

(e) *Genital examination of females*

226. In many cultures, it is completely unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. If the woman demonstrates clear evidence of rape on external inspection, it may be unnecessary to conduct an internal pelvic examination. Genital examination findings may include:

(i) Small lacerations or tears of the vulva. These may be acute and are caused by excessive stretching. They normally heal completely, but, if repeatedly traumatized, there may be scarring;

(ii) Abrasions of the female genitalia. Abrasions can be caused by contact with rough objects such as fingernails or rings;

(iii) Vaginal lacerations. These are rare, but, if present, may be associated with atrophy of the tissues or previous surgery. They cannot be differentiated from incisions caused by inserted sharp objects.

227. It is rare to find any physical evidence when examining female genitalia more than one week after an assault. Later on, when the woman may have had subsequent sexual activity, whether consensual or not, or given birth, it may be almost impossible to attribute any findings to a specific incident of alleged abuse. Therefore, the most significant component of a medical evaluation may be the examiner's assessment of background information (for example, correlation between allegations of abuse and acute injuries observed by the individual) and demeanour of the individual, bearing in mind the cultural context of the woman's experience.

(f) *Genital examination of males*

228. Men who have been subjected to torture of the genital region, including the crushing, wringing or pulling of the scrotum or direct trauma to that region, usually complain of pain and sensitivity in the acute period. Hyperaemia, marked swelling and ecchymosis can be observed. The urine may contain a large number of erythrocytes and leucocytes. If a mass is detected, it should be determined whether it is a hydrocele, haematocele or inguinal hernia. In the case of an inguinal hernia, the examiner cannot palpate the spermatic cord above the mass. With a hydrocele or a haematocele, normal spermatic cord structures are usually palpable above the mass. A hydrocele results from excessive accumulation of fluid within the tunica vaginalis due to inflammation of the testis and its appendages or to diminished drainage secondary to lymphatic or venous obstruction in the cord or retroperitoneal space. A haematocele is an accumulation of blood within the tunica vaginalis, secondary to trauma. Unlike the hydrocele, it does not transilluminate.

229. Testicular torsion may also result from trauma to the scrotum. With this injury, the testis becomes twisted at its base, obstructing blood flow to the testis. This causes severe pain and swelling and constitutes a surgical emergency. Failure to reduce the torsion immediately will lead to infarction of the testis. Under conditions of detention, where medical care may be denied, late sequelae of this lesion may be observed.

230. Individuals who were subject to scrotal torture may suffer from chronic urinary tract infection, erectile dysfunction or atrophy of the testes. Symptoms of post-traumatic stress disorder are not uncommon. In the chronic phase, it may be impossible to distinguish between scrotal pathology caused by torture and that caused by other disease processes. Failure to discover any physical abnormalities on full urological examination suggests that urinary symptoms, impotence or other sexual problems may be explained on psychological grounds. Scars on the skin of the scrotum and penis may be very difficult to visualize. For this reason, the absence of scarring at these specific locations does not demonstrate the

CHAPTER VI

PSYCHOLOGICAL EVIDENCE OF TORTURE

A. General considerations

1. *The central role of the psychological evaluation*

233. It is a widely held view that torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individual's pre-torture psychological status. The psychological consequences of torture, however, occur in the context of personal attribution of meaning, personality development and social, political and cultural factors. For this reason, it cannot be assumed that all forms of torture have the same outcome. For example, the psychological consequences of a mock execution are not the same as those due to a sexual assault, and solitary confinement and isolation are not likely to produce the same effects as physical acts of torture. Likewise, one cannot assume that the effects of detention and torture on an adult will be the same as those on a child. Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity.

234. Perpetrators often attempt to justify their acts of torture and ill-treatment by the need to gather information. Such conceptualizations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions.[92] Thus, torture is a means of attacking an individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate physically a victim but also to disintegrate the individual's personality. The torturer attempts to destroy a victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. By dehumanizing and breaking the will of their victims, torturers set horrific examples for those who later come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children, other family members and relationships between the victims and their communities.

235. It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness. However, many victims experience profound emotional reactions and psychological symptoms. The main psychiatric disorders associated with torture are post-traumatic stress disorder (PTSD) and major depression. While these disorders are present in the general population, their prevalence is much higher among traumatized populations. The unique cultural, social and political implications that torture has for each individual influence his or her ability to describe and speak about it. These are important factors that contribute to the impact that torture inflicts psychologically and socially and that must be considered when performing an evaluation of an individual from another culture. Cross-cultural research reveals that phenomenological or descriptive methods are the most rational approaches to use when attempting to evaluate psychological or psychiatric disorders. What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another.[93,94,95] Since the Second World War, progress has been made towards understanding the psychological consequences of violence. Certain psychological symptoms and clusters of symptoms have been observed and documented among survivors of torture and other types of violence.

236. In recent years, the diagnosis of post-traumatic stress disorder has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence. However, the utility of this diagnosis in non-western cultures has not been established. Nevertheless, evidence suggests that there are high rates of post-traumatic stress disorder and depression symptoms among traumatized refugee populations from many different ethnic and cultural backgrounds.[96,97,98]

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[92] G. Fischer and N. F. Gurris, "Grenzverletzungen: Folter und sexuelle Traumatisierung", *Praxis der Psychotherapie-Ein integratives Lehrbuch für Psychoanalyse und Verhaltenstherapie*, W. Senf and W. Broda, eds. (Stuttgart, Thieme, 1996).

[93] A. Kleinman, "Anthropology and psychiatry: the role of culture in cross-cultural research on illness and care", paper delivered at the WPA regional symposium on psychiatry and its related disciplines, 1986.

[94] H. T. Engelhardt, "The concepts of health and disease", *Evaluation and Explanation in the Biomedical Sciences*, H.T. Englehardt and S.F. Spicker, eds. (Dordrecht: D. Reidel Publishing Co., 1975:125-141).

[95] J. Westermeyer, "Psychiatric diagnosis across cultural boundaries", *American Journal of Psychiatry* (142(7) 1985:798-805).

[96] R. F. Mollica, K. Donelan, S. Tor et al., "The effect of trauma and confinement on the functional health and mental health status of Cambodians living in Thailand-Cambodia border camps", *Journal of the American Medical Association (JAMA)* (270 1993:581-586).

[97] J. D. Kinzie et al. ,"The prevalence of post-traumatic stress disorder and its clinical significance among Southeast Asian refugees", *American Journal of Psychiatry* (147(7) 1990:913-917).

[98] K. Allden et al., "Burmese political dissidents in Thailand: trauma; and survival among young adults in exile", *American Journal of Public Health* (86 1996:1561-1569).

ished interest or pleasure in activities), appetite disturbance or weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness and excessive guilt, difficulty paying attention, concentrating or recalling from memory, thoughts of death and dying, suicidal ideation or attempted suicide.

(e) *Damaged self-concept and foreshortened future*

242. The victim has a subjective feeling of having been irreparably damaged and having undergone an irreversible personality change.[102] He or she has a sense of foreshortened future without expectation of a career, marriage, children or normal lifespan.

(f) *Dissociation, depersonalization and atypical behaviour*

243. Dissociation is a disruption in the integration of consciousness, self-perception, memory and actions. A person may be cut off or unaware of certain actions or may feel split in two as if observing him or herself from a distance. Depersonalization is feeling detached from oneself or one's body. Impulse control problems result in behaviours that the survivor considers highly atypical with respect to his or her pre-trauma personality. A previously cautious individual may engage in high-risk behaviour.

(g) *Somatic complaints*

244. Somatic symptoms such as pain, headache or other physical complaints, with or without objective findings, are common problems among torture victims. Pain may be the only manifest complaint and may shift in location and vary in intensity. Somatic symptoms can be directly due to physical consequences of torture or psychological in origin. For example, pain of all kinds may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal pain and headaches, often from head injuries. Headaches are very common among torture survivors and often lead to chronic post-traumatic headaches. They may also be caused or exacerbated by tension and stress.

(h) *Sexual dysfunction*

245. Sexual dysfunction is common among survivors of torture, particularly among those who have suffered sexual torture or rape, but not exclusively (see chapter V.D.8.).

(i) *Psychosis*

246. Cultural and linguistic differences may be confused with psychotic symptoms. Before labelling someone as psychotic, the symptoms must be evaluated within the individual's unique cultural context. Psychotic reactions may be brief or prolonged, and the symptoms may occur while the person was detained and tortured or afterwards. The following findings are possible:

(i) Delusions;

(ii) Auditory, visual, tactile and olfactory hallucinations;

(iii) Bizarre ideation and behaviour;

(iv) Illusions or perceptual distortions that may take the form of pseudo-hallucinations and border on true psychotic states. False perceptions and hallucinations that occur on falling asleep or on waking are common among the general population and do not denote psychosis. It is not uncommon for torture victims to report occasionally hearing screams, his or her name being called or seeing shadows, but not have florid signs or symptoms of psychosis;

(v) Paranoia and delusions of persecution;

(vi) Recurrence of psychotic disorders or mood disorders with psychotic features may develop among those who have a past history of mental illness. Individuals with a past history of bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder.

(j) *Substance abuse*

247. Alcohol and drug abuse often develops secondarily in torture survivors as a way of obliterating traumatic memories, regulating affects and managing anxiety.

(k) *Neuropsychological impairment*

248. Torture can cause physical trauma that leads to various levels of brain impairment. Blows to the head, suffocation and prolonged malnutrition may have long-term neurological and neuropsychological consequences that may not be readily assessed during the course of a medical examination. As in all cases of brain impairment that cannot be documented through head imaging or other medical procedures, neuropsychological assessment and testing may be the only reliable way of documenting the effects. Frequently, the target symptoms for such assessments have significant overlap with the symptomatology arising from post-traumatic stress disorder and major depressive disorder. Fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning may result from functional disturbances as well as organic causes. Therefore, specialized skill in neuropsychological assessment and awareness of problems in cross-cultural validation of neuropsychological instruments is necessary when such distinctions are to be made (see section C.4. below).

3. *Diagnostic classifications*

249. While the chief complaints and most prominent findings among torture survivors are widely diverse and relate to the individual's unique life experiences and his or her cultural, social and political context, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors. Also, it is not uncommon for more than one mental disor-

[102] N. R. Holtan, "How medical assessment of victims of torture relates to psychiatric care", *Caring for Victims of Torture*, J. M. Jaranson and M. K. Popkin, eds. (Washington, D. C., American Psychiatric Press, 1998:107-113).

victim of terrorism, and torture. According to ICD-10, the diagnosis of an enduring change in personality should be made only when there is evidence of a definite, significant and persistent change in the individual's pattern of perceiving, relating or thinking about the environment and him or herself, associated with inflexible and maladaptive behaviours not present before the traumatic experience. The diagnosis excludes changes that are a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder, as well as personality and behavioural changes due to brain disease, dysfunction or damage.

256. To make the ICD-10 diagnosis of enduring personality change after catastrophic experience, the changes in personality must be present for at least two years following exposure to catastrophic stress. ICD-10 specifies that the stress must be so extreme that "it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality". This personality change is characterized by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge", as if constantly threatened, and estrangement.

(d) *Substance abuse*

257. Clinicians have observed that alcohol and drug abuse often develop secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant affects and managing anxiety. Although co-morbidity of PTSD with other disorders is common, systematic research has seldom studied the abuse of substances by torture survivors. The literature on populations that suffer from PTSD may include torture survivors, such as refugees, prisoners of war and veterans of armed conflicts, and may provide some insight. Studies of these groups reveal that prevalence of substance abuse varies by ethnic or cultural group. Former prisoners of war with PTSD were at increased risk for substance abuse, and combat veterans have high rates of co-morbidity of post-traumatic stress disorder and substance abuse.[105, 106, 107, 108, 109, 110, 111, 112] In summary, there is considerable evidence from other populations at risk of post-traumatic stress disorder that substance abuse is a potential co-morbid diagnosis for torture survivors.

(e) *Other diagnoses*

258. As is evident from the catalogue of symptoms described in this section, there are other diagnoses to be considered in addition to post-traumatic stress disorder, such as major depressive disorder and enduring personality change. The other possible diagnoses include but are not limited to:

(i) Generalized anxiety disorder features excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity;

(ii) Panic disorder is manifested by recurrent and unexpected attacks of intense fear or discomfort, including symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flushes;

(iii) Acute stress disorder has essentially the same symptoms as PTSD but is diagnosed within one month of exposure to the traumatic event;

(iv) Somatoform disorders featuring physical symptoms that cannot be accounted for by a medical condition;

(v) Bipolar disorder featuring manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas, psychomotor agitation and associated psychotic phenomena;

(vi) Disorders due to a general medical condition often in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning;

(vii) Phobias such as social phobia and agoraphobia.

C. The psychological/psychiatric evaluation

1. *Ethical and clinical considerations*

259. Psychological evaluations can provide critical evidence of abuse among torture victims for several reasons: torture often causes devastating psychological symptoms, torture methods are often designed to leave no physical lesions and physical methods of torture may result in physical findings that either resolve or lack specificity.

260. Psychological evaluations provide useful evidence for medico-legal examinations, political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practices of torture, identifying the therapeutic needs of victims and as testimony in human rights investigations. The overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation. To this end, the evaluation should provide a detailed description of the

[105] P. J. Farias, "Emotional distress and its socio-political correlates in Salvadoran refugees: analysis of a clinical sample", *Culture, Medicine and Psychiatry* (15 1991:167-192).

[106] A. Dadfar "The Afghans: bearing the scars of a forgotten war", *Amidst peril and pain*, A. Marsella et al. (Washington, D. C., American Psychological Association, 1994).

[107] G. W. Beebe, "Follow-up studies of World War II and Korean war prisoners, II: morbidity, disability, and malajustments", *American Journal of Epidemiology* (101 1975:400-422).

[108] B. E. Engdahl et al., "The comorbidity and course of psychiatric disorders in a community sample of former prisoners of war", in review.

[109] T. M. Keane and J. Wolfe, "Comorbidity in post-traumatic stress disorder: an analysis of community and clinical studies", *Journal of Applied Social Psychology* (20(21, 1) 1990:1776-1788).

[110] R. A. Kulka et al., *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* (New York, Brunner/Mazel, 1990).

[111] K. Jordan et al., "Lifetime and current prevalence of specific psychiatric disorders among Vietnam veterans and controls", *Archives of General Psychiatry* (48(3) 1991:207-215).

[112] A. Y. Shalev, A. Bleich, R. J. Ursano, "Post-traumatic stress disorder: somatic comorbidity and effort tolerance", *Psychosomatics* (31(2) 1990:197-203).

minority group or culture. This dynamic of inequality may reinforce the perceived and real imbalance of power and may increase the potential sense of fear, mistrust and forced submission in the subject. In some cases, particularly with subjects still in custody, this dynamic may relate more to the interpreter than the evaluator. Ideally, therefore, the interpreter should also be an outsider and not be recruited locally, so that he or she can be seen by all to be as independent as the investigator. Of course, a family member on whom the authorities can later apply pressure to find out what was discussed in the evaluation should not be used as an interpreter.

269. If the evaluator and the victim are of the same gender, the interview may be more readily perceived as directly resembling the torture situation than if the genders were different. For example, a woman who was raped or tortured in prison by a male guard is likely to experience more distress, mistrust and fear when facing a male evaluator than she might with a female interviewer. The opposite is true for men who have been assaulted sexually. They may be ashamed to tell the details of their torture to a female evaluator. Experience has shown, particularly in cases of victims still in custody, that in all but the most traditionally fundamentalist societies (where it is out of the question for a male to even interview, let alone examine a woman), it may be much more important that the interviewer be a physician to whom the victim can ask precise questions, rather than not being a male as in a case of rape. Victims of rape have been known to say nothing to non-medical female investigators, but request to talk to a physician, even if male, so as to be able to ask specific medical questions. Typical questions are about possible sequelae, such as being pregnant, being able to conceive later on or about the future of sexual relations between spouses. In the context of evaluations conducted for legal purposes, the necessary attention to detail and precise questioning about history are easily perceived as a sign of mistrust or doubt on the part of the examiner.

270. Because of the psychological pressures mentioned earlier, survivors may be re-traumatized and overwhelmed by memories and, as a result, affect or mobilize strong defences that result in profound withdrawal and affective flattening during examination or interview. For the purposes of documentation, the withdrawal and flattening present special difficulties because torture victims may be unable to communicate effectively their history and current suffering, although it would be most beneficial for them to do so.

271. Countertransference reactions are often unconscious, and when one is unaware of countertransference, it becomes a problem. Having feelings when listening to individuals speak of their torture is to be expected, although these feelings can interfere with the clinician's effectiveness, but when understood they can guide the clinician. Physicians and psychologists involved in the evaluation and treatment of torture victims agree that awareness and understanding of typical countertransference reactions are crucial because countertransference can have significantly limiting effects on the ability to evaluate and document the physical and psychological consequences of torture. Effective documentation of torture and other forms of ill-treatment requires an understanding of personal motivations for working in this area. There is a consensus that professionals who continuously conduct this kind of examination should obtain supervision and professional support from peers who are experienced in this field. Common countertransference reactions include:

(i) Avoidance, withdrawal and defensive indifference in reaction to being exposed to disturbing material. This may lead to forgetting some details and underestimating the severity of physical or psychological consequences;

(ii) Disillusionment, helplessness, hopelessness and over-identification that may lead to symptoms of depression or vicarious traumatization, such as nightmares, anxiety and fear;

(iii) Omnipotence and grandiosity in the form of feeling like a saviour, the great expert on trauma or the last hope for the survivor's recovery and well-being;

(iv) Feelings of insecurity about one's professional skills when faced with the gravity of the reported history or suffering. This may manifest as lack of confidence in one's ability to do justice to the survivor and unrealistic preoccupation with idealized medical norms;

(v) Feelings of guilt over not sharing the torture survivor's experience and pain or over the awareness of what has not been done on a political level may result in overly sentimental or idealized approaches to the survivor;

(vi) Anger and rage towards torturers and persecutors are expectable, but may undermine the ability to maintain objectivity when they are driven by unrecognized personal experiences and thus become chronic or excessive;

(vii) Anger or repugnance against the victim may arise as a result of feeling exposed to unaccustomed levels of anxiety. This also may arise as a result of feeling used by the victim when the clinician experiences doubt about the truth of the alleged torture history and the victim stands to benefit from an evaluation that documents the consequences of the alleged incident;

(viii) Significant differences between the cultural value systems of the clinician and the individual alleging torture may include belief in myths about ethnic groups, condescending attitudes and underestimation of the individual's sophistication or capacity for insight. Conversely, clinicians who are members of the same ethnic group as a victim might form a non-verbalized alliance that can also affect the objectivity of the evaluation.

272. Most clinicians agree that many countertransference reactions are not merely examples of distortion but are important sources of information about the psychological state of the torture victim. The clinician's effectiveness can be compromised when countertransference is acted upon rather than reflected upon. Clinicians engaged in the evaluation and treatment of torture victims are advised to examine countertransference and obtain

nonetheless, to obtain enough data about the individual's previous mental health and psychosocial functioning to obtain an impression of the degree to which torture has contributed to psychological problems.

(e) *Medical history*

280. The medical history summarizes pre-trauma health conditions, current health conditions, body pain, somatic complaints, use of medication and their side effects, relevant sexual history, past surgical procedures and other medical data (see chapter V.B.).

(f) *Psychiatric history*

281. Inquiry should be made about a history of mental or psychological disturbances, the nature of problems and whether they received treatment or required psychiatric hospitalization. The inquiry should also cover prior therapeutic use of psychotropic medication.

(g) *Substance use and abuse history*

282. The clinician should inquire about substance use before and after the torture, changes in the pattern of use and whether substances are being used to cope with insomnia or psychological/psychiatric problems. These substances are not only alcohol, cannabis and opium but also regional substances of abuse such as betel nut and many others.

(h) *Mental status examination*

283. The mental status examination begins the moment the clinician meets the subject. The interviewer should make note of the person's appearance, such as signs of malnutrition, lack of cleanliness, changes in motor activity during the interview, use of language, presence of eye contact, ability to relate to the interviewer and the means the individual uses to establish communication. The following components should be covered, and all aspects of the mental status examination should be included in the report of the psychological evaluation; aspects such as general appearance, motor activity, speech, mood and affect, thought content, thought process, suicidal and homicidal ideation and a cognitive examination (orientation, long-term memory, intermediate recall and immediate recall).

(i) *Assessment of social function*

284. Trauma and torture can directly and indirectly affect a person's ability to function. Torture can also indirectly cause loss of functioning and disability, if the psychological consequences of the experience impair the individual's ability to care for himself or herself, earn a living, support a family and pursue an education. The clinician should assess the individual's current level of functioning by inquiring about daily activities, social role (as housewife, student, worker), social and recreational activities and perception of health status. The interviewer should ask the individual to assess his or her own health condition, to state the presence or absence of feelings of chronic fatigue and to report potential changes in overall functioning.

(j) *Psychological testing and the use of checklists and questionnaires*

285. Little published data exist on the use of psychological testing (projective and objective personality tests) in the assessment of torture survivors. Also, psychological tests of personality lack cross-cultural validity. These factors combine to limit severely the utility of psychological testing in the evaluation of torture victims. Neuropsychological testing may, however, be helpful in assessing cases of brain injury resulting from torture (see section C.4. below). An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases, it may be helpful to use trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to use trauma event and symptom checklists, there are numerous questionnaires available, although none are specific to torture victims.

(k) *Clinical impression*

286. In formulating a clinical impression for the purposes of reporting psychological evidence of torture, the following important questions should be asked:

(i) Are the psychological findings consistent with the alleged report of torture?

(ii) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

(iii) Given the fluctuating course of trauma-related mental disorders over time, what is the timeframe in relation to the torture events? Where is the individual in the course of recovery?

(iv) What are the coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?

(v) Which physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture or detention;

(vi) Does the clinical picture suggest a false allegation of torture?

287. Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged abuse. The emotional state and expression of the person during the interview, his or her symptoms, the history of detention and torture and the personal history prior to torture should be described. Factors such as the onset of specific symptoms related to the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should be noted. Additional factors, such as forced migration, resettlement, difficulty of acculturation, language problems, unemployment, loss of home, family and social status should be considered. The relationship and consistency between events and symptoms should be evaluated and described. Physical conditions, such as head trauma or brain injury, may require further evaluation. Neurological or neuropsychological assessment may be recommended.

tion, an analysis of the lateralization (or localization) of deficits is more difficult. This analysis is often useful, however, because of the brain's asymmetrical organization, with the left hemisphere typically being dominant for speech. If population-based norms are unavailable for the subject's cultural and linguistic group, neuropsychological assessment is also of questionable validity. An estimate of IQ is one of the central benchmarks that allow examiners to place neuropsychological test scores into proper perspective. Within the population of the United States, for example, these estimates are often derived from verbal subsets using the Wechsler scales, particularly the information subscale, because in the presence of organic brain impairment, acquired factual knowledge is less likely to suffer deterioration than other tasks and be more representative of past learning ability than other measures. Measurement may also be based on educational and work history and demographic data. Obviously, neither one of these two considerations applies to subjects for whom population-based norms have not been established. Therefore, only very coarse estimates concerning pre-trauma intellectual functioning can be made. As a result, neuropsychological impairment that is anything less than severe or moderate may be difficult to interpret.

296. Neuropsychological assessments may re-traumatize those who have experienced torture. Great care must be taken in order to minimize any potential re-traumatization of the subject in any form of diagnostic procedure (see chapter IV.H.). To cite only one obvious example specific to neuropsychological testing, it would be potentially very damaging to proceed with a standard administration of the Halstead-Reitan Battery, in particular the Tactual Performance Test (TPT), and routinely blindfold the subject. For most torture victims who have experienced blindfolding during detention and torture, and even for those who were not blindfolded, it would be very traumatic to introduce the experience of helplessness inherent in this procedure. In fact, any form of neuropsychological testing in itself may be problematic, regardless of the instrument used. Being observed, timed with a stopwatch and asked to give maximum effort on an unfamiliar task, in addition to being asked to perform, rather than having a dialogue, may prove to be too stressful or reminiscent of the torture experience.

(b) *Indications for neuropsychological assessment*

297. In evaluating behavioural deficits in suspected torture victims, there are two primary indications for neuropsychological assessment: brain injury and post-traumatic stress disorder plus related diagnoses. While both sets of conditions overlap in some aspects, and will often coincide, it is only the former that is a typical and traditional application of clinical neuropsychology, whereas the latter is relatively new, not well researched and rather problematic.

298. Brain injury and resulting brain damage may result from various types of head trauma and metabolic disturbances inflicted during periods of persecution, detention and torture. This may include gunshot wounds, the effects of poisoning, malnutrition as a result of starvation or forced ingestion of harmful substances, the effects of hypoxia or anoxia resulting from asphyxiation or near drowning and, most commonly, from blows to the head suffered during beatings. Blows to the head are frequently inflicted during periods of detention and torture. For example, in one sample of torture survivors, blows to the head were the second most frequently cited form of bodily abuse (45 per cent) behind blows to the body (58 per cent).[117] The potential for brain damage is high among torture victims.

299. Closed head injuries resulting in mild to moderate levels of long-term impairment are perhaps the most commonly assessed cause of neuropsychological abnormality. While signs of injury may include scars on the head, brain lesions cannot usually be detected by diagnostic imaging of the brain. Mild to moderate levels of brain damage might be overlooked or underestimated by mental health professionals because symptoms of depression and post-traumatic stress disorder are likely to figure prominently in the clinical picture, resulting in less attention being paid to the potential effect of head trauma. Commonly, the subjective complaints of survivors include difficulties with attention, concentration and short-term memory, which can be the result of either brain impairment or post-traumatic stress disorder. Since these complaints are common in survivors suffering from post-traumatic stress disorder, the question whether they are actually due to head injury may not even be asked.

300. The diagnostician must rely, in an initial phase of the examination, on reported history of head trauma and the course of symptomatology. As is usually the case with brain-injured subjects, information from third parties, particularly relatives, may prove helpful. It must be remembered that brain-injured subjects often have great difficulty articulating or even appreciating their limitations because they are, so to speak, "inside" the problem. In gathering first impressions regarding the difference between organic brain impairment and post-traumatic stress disorder, an assessment concerning the chronicity of symptoms is a helpful starting point. If symptoms of poor attention, concentration and memory are observed to fluctuate over time and to co-vary with levels of anxiety and depression, this is more likely due to the phasic nature of post-traumatic stress disorder. On the other hand, if impairment seems to appear chronic, lacks fluctuation and is confirmed by family members, the possibility of brain impairment should be entertained, even in the initial absence of a clear history of head trauma.

301. Once there is a suspicion of organic brain impairment, the first step for a mental health professional is to consider a referral to a physician for further neurological examination. Depending on initial findings, the physician may then consult a neurologist or order diagnostic tests. An extensive medical work-up, specific neurological consultation and neuropsychological evaluation are among the possibilities to be considered. The use of neuropsychological evaluation procedures are usually indicated if there is a lack of gross neurological disturbance, reported symptoms are predominantly cognitive in nature or a differential diagnosis between brain impairment and post-traumatic stress disorder has to be made.

[117] H. C. Traue, G. Schwarz-Langer, N. F. Gurris, "Extremtraumatisierung durch Folter. Die psychotherapeutische Arbeit der Behandlungszentren für Folteropfer", *Verhaltenstherapie und Verhaltensmedizin* (1 1997:41–62).

of torture victims. A complete discussion of the psychological impact of torture on children and complete guidelines for conducting an evaluation of a child who has been tortured is beyond the scope of this manual. Nevertheless, several important points can be summarized.

310. First, when evaluating a child who is suspected of having undergone or witnessed torture, the clinician must make sure that the child receives support from caring individuals and that he or she feels secure during the evaluation. This may require a parent or trusted care provider to be present during the evaluation. Second, the clinician must keep in mind that children often do not express their thoughts and emotions regarding trauma verbally, but rather behaviourally.[123] The degree to which children are able to verbalize thought and affect depends on the child's age, developmental level and other factors, such as family dynamics, personality characteristics and cultural norms.

311. If a child has been physically or sexually assaulted, it is important, if at all possible, for the child to be seen by an expert in child abuse. Genital examination of children, likely to be experienced as traumatic, should be performed by clinicians experienced in interpreting the findings. Sometimes it is appropriate to videotape the examination so that other experts can give opinions on the physical findings without the child having to be examined again. It may be inappropriate to perform a full genital or anal examination without a general anaesthetic. Furthermore, the examiner should be aware that the examination itself may be reminiscent of the assault and it is possible that the child may make a spontaneous outcry or psychologically decompensate during the examination.

(a) *Developmental considerations*

312. A child's reactions to torture depend on age, developmental stage and cognitive skills. The younger the child, the more his or her experience and understanding of the traumatic event is influenced by the immediate reactions and attitudes of caregivers following the event.[124] For children under the age of three who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.[125] The reactions of very young children to traumatic experiences typically involve hyperarousal, such as restlessness, sleep disturbance, irritability, heightened startle reactions and avoidance. Children over three often tend to withdraw and refuse to speak directly about traumatic experiences. The ability for verbal expression increases during development. A marked increase occurs around the concrete operational stage (8-9 years old), when children develop the ability to provide a reliable chronology of events. During this stage, concrete operations and temporal and spatial capacities develop.[126] These new skills are still fragile, and it is usually not until the beginning of the formal operational stage (12 years old) that children are consistently able to construct a coherent narrative. Adolescence is a turbulent developmental period. The effects of torture can vary widely. Torture experiences may cause profound personality changes in adolescents resulting in antisocial behaviour.[127] Alternatively, the effects of torture on adolescents may be similar to those seen in younger children.

(b) *Clinical considerations*

313. Symptoms of post-traumatic stress disorder may appear in children. The symptoms can be similar to those observed in adults, but the clinician must rely more heavily on observations of the child's behaviour than on verbal expression.[128, 129, 130, 131] For example, the child may demonstrate symptoms of re-experiencing as manifested by monotonous, repetitive play representing aspects of the traumatic event, visual memories of the events in and out of play, repeated questions or declarations about the traumatic event and nightmares. The child may develop bedwetting, loss of control of bowel movements, social withdrawal, restricted affect, attitude changes towards self and others and feelings that there is no future. He or she may experience hyperarousal and have night terrors, problems going to bed, sleep disturbance, heightened startle response, irritability and significant disturbances in attention and concentration. Fears and aggressive behaviour that were non-existent before the traumatic event may appear as aggressiveness towards peers, adults or animals, fear of the dark, fear of going to the toilet alone and phobias. The child may demonstrate sexual behaviour that is inappropriate for his or her age and somatic reactions. Anxiety symptoms, such as exaggerated fear of strangers, separation anxiety, panic, agitation, temper tantrums and uncontrolled crying may appear. The child may also develop eating problems.

(c) *Role of the family*

314. The family plays an important dynamic role in persisting symptomatology among children. In order to preserve cohesion in the family, dysfunctional behaviours and delegation of roles may occur. Family members, often children, can be assigned the role of patient and develop severe disorders. A child may be overly protected or important facts about the trauma may be hidden. Alternatively, the child can be parentified and expected to care for the parents. When the child is not the direct victim of torture but only indirectly affected, adults often tend to underestimate the impact on the child's psyche and devel-

[123] C. Schlar, "Evaluation and documentation of psychological evidence of torture", unpublished paper, 1999.

[124] Ottino S. von Overbeck, "Familles victimes de violences collectives et en exil: quelle urgence, quel modèle de soins ? Le point de vue d'une pédopsychiatre", *La Revue Française de Psychiatrie et de Psychologie Médicale* (14 1998:35-39).

[125] M. Grappe, "La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés", *Psychiatrie humanitaire en ex-Yougoslavie et en Arménie. Face au traumatisme*, M. R. Moro and S. Lebovici, eds. (Paris, PUF, 1995).

[126] J. Piaget, *La naissance de l'intelligence chez l'enfant* (Neuchâtel, Delachaux et Niestlé, 1977).

[127] See footnote 125.

[128] L. C. Terr, "Childhood traumas: an outline and overview", *American Journal of Psychiatry* (148 1991:10-20).

[129] National Center for Infants, Toddlers and Families, *Zero to Three* (1994).

[130] F. Sironi, "On torture un enfant, ou les avatars de l'ethnocentrisme psychologique", *Enfances* (4 1995:205-215).

[131] L. Bailly, *Les catastrophes et leurs conséquences psychotraumatiques chez l'enfant* (Paris, ESF, 1996).

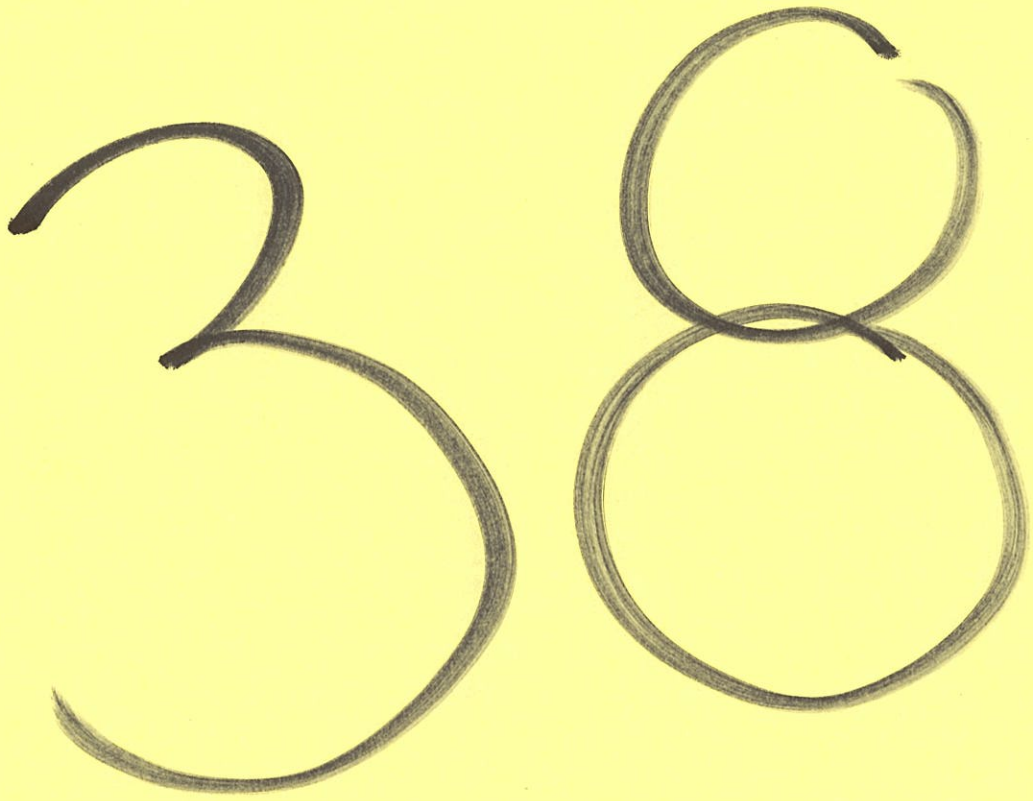
37

Oath of Office

The Oath of Office, which must be signed and agreed to orally by U.S. citizens on Induction Day, states the following:

"I,_____, having been appointed a midshipman in the United States Navy, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter, so help me God."

This oath will be reaffirmed by the Fourth Class Midshipmen at the conclusion of Plebe Summer.



UNITING AND STRENGTHENING AMERICA BY PROVIDING APPROPRIATE TOOLS REQUIRED TO INTERCEPT AND OBSTRUCT TERRORISM (USA PATRIOT ACT) ACT OF 2001

"(2) shall specify that the records concerned are sought for an authorized investigation conducted in accordance with subsection (a)(2) to obtain foreign intelligence information not concerning a United States person or to protect against international terrorism or clandestine intelligence activities.

"(c)(1) Upon an application made pursuant to this section, the judge shall enter an ex parte order as requested, or as modified, approving the release of records if the judge finds that the application meets the requirements of this section.

"(2) An order under this subsection shall not disclose that it is issued for purposes of an investigation described in subsection (a).

"(d) No person shall disclose to any other person (other than those persons necessary to produce the tangible things under this section) that the Federal Bureau of Investigation has sought or obtained tangible things under this section.

"(e) A person who, in good faith, produces tangible things under an order pursuant to this section shall not be liable to any other person for such production. Such production shall not be deemed to constitute a waiver of any privilege in any other proceeding or context.

Notebook

Psychological Torture?

By DOUGLAS WALLER

Mar. 28, 2005

Military interrogators often have to play mind games with their Iraqi and Afghan prisoners in an effort to extract information. But how far should mental-health experts go in helping play those games? A report on detainee abuse, delivered to Congress on March 7 by Vice Admiral Albert Church, noted that there is "a growing trend in the global war on terror" for military psychiatrists and psychologists to take part in interrogations. Now some mental-health professionals, even within the military, are growing concerned that colleagues who have helped interrogators may have broken the first rule of medical ethics: Do no harm. The American Psychological Association has organized a task force to investigate the work--much of which is shrouded in secrecy--and to craft ethical guidelines for it.

The role most psychologists and psychiatrists play in these interrogations may be relatively benign. One military psychologist described for TIME the help he gave intelligence officers in Afghanistan in getting an unruly Taliban prisoner to cooperate--coaxing information from the prisoner by starting "very gently" with innocuous questions about his family history, until the prisoner "talked and talked."

But the Army Surgeon General is investigating whether some doctors helped direct what amounts to psychological torture. Though no evidence has surfaced that mental-health professionals sanctioned the beatings and sexual humiliation that guards at Abu Ghraib are accused of inflicting, Army investigators did find that military-intelligence officers at the prison had psychiatrists review their "interrogation plans" for Iraqi detainees. If any mental-health professionals supervised such pressure tactics as sleep deprivation or the use of military dogs to threaten prisoners during interrogations, that would cross an ethical line, says an Army psychiatrist. "We should not be using our abilities to make things difficult for a person," the psychiatrist told TIME. "I'd like to think that no mental-health people were involved in that, but there may have been some blurring of the boundaries." --By Douglas Waller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PERSPECTIVE

Without Conscience

Elie Wiesel

This is one of those stories that invite fear.

Now we know. During the period of the past century that I call Night, medicine was practiced in certain places not to heal but to harm, not to fight off death but to serve it.

In the conflict between Good and Evil during the Second World War, the infamous Nazi doctors played a crucial role. They preceded the torturers and assassins in the science of organized cruelty that we call the Holocaust. There is a Talmudic adage, quite disturbing, that applies to them: *Tov shebarofim le-gehinom* — "The best doctors are destined for hell." The Nazi doctors made hell.

Inspired by Nazi ideology and implemented by its apostles, eugenics and euthanasia in the late 1930s and early 1940s served no social necessity and had no scientific justification. Like a poison, they ultimately contaminated all intellectual activity in Germany. But the doctors were the precursors. How can we explain their betrayal? What made them forget or eclipse the Hippocratic Oath? What gagged their conscience? What happened to their humanity?

In all truth, the medical field was not the only one to subscribe to Hitler's plan. There was the judicial profession. And in some ways, the church. Only the literary world retained its sense of honor: the great writers, for the most part, were exiled. Not only Jews — Thomas Mann and Bertolt Brecht were not Jewish, but they were unable to breathe in the stifling air of the Third Reich. Doctors, on the other hand, mostly stayed — not the Jewish ones, but the others.

We know the facts. The motives as well. One day, Hitler and Himmler's health minister made it known to leaders in the medical field that, according to a secret decision made at the highest level, it was necessary to get rid of "useless mouths" — the insane, the terminally ill, children, and elderly people who were condemned to misfortune by nature and to suffering and fear by God. Few in the German medical profession believed it worthy or good to refuse.

Thus, instead of doing their job, instead of bringing assistance and comfort to the sick people who needed them most, instead of helping the mutilated and the handicapped to live, eat, and hope one more day, one more hour, doctors became their executioners.

In October 1939, several weeks after the beginning of hostilities, Hitler gave the first order concerning the *Gnadentod*, or "charitable death." On the 15th of that month, gas was used for the first time to kill "patients" in Poznán, Poland. But similar centers had already been created in Germany three years earlier. Now, psychiatrists and other doctors collaborated in a professional atmosphere exemplary for its camaraderie and efficiency. In less than two years, 70,000 sick people disappeared into the gas chambers. The *Gnadentod* program was going so well that the head of the Wehrmacht Hospital psychiatric ward, Professor Wurth, worried, "With all the mentally ill being eliminated, who will want to pursue studies in the burgeoning field of psychiatry?" The program was interrupted only when the bishop of Münster, Clemens August Graf von Galen, had the courage to denounce it from his cathedral's pulpit; protest, in other words, came not from the medical profession, but from the church. Finally, public opinion was moved: too many German families were directly affected.

Like the fanatical German theorists, Nazi doctors did their work without any crisis of conscience.

Professor Wiesel was awarded the Nobel Peace Prize in 1986. He is a university professor of religion and philosophy at Boston University, Boston. Sixty years ago, on April 11, 1945, he was liberated from the Buchenwald concentration camp.

only following orders. But the Nazi doctors? None among them acted under duress — neither those who presided over the nocturnal division of new arrivals, nor those who killed the prisoners in their laboratories. They could have slipped away; they could have said no. Until the end, they considered themselves public servants loyal to German politics and science. In other words, patriots, devoted researchers. Without too great a stretch, maybe even societal benefactors. Martyrs.

Must one conclude that, since a humane science exists, there was also a science that wasn't humane? I won't even consider racist theorists who tried to treat racism as an exact science. Their vulgar stupidity deserves nothing but disdain. But there were excellent physicians, well-informed chemists, and great surgeons — all racist. How could they seek truth and happiness for human beings at the same time that they hated some of them solely because they belonged to human communities other than their own?

One of the brutal shocks of my adult life came the day I discovered that many of the officers of the *Einsatzgruppen* — the death commandos in Eastern Europe — had received degrees from Germany's best universities. Some held doctorates in literature, others in philosophy, theology, or history. They had spent many years studying, learning the lessons of past generations, yet nothing kept them from killing Jewish children at Babi Yar, in Minsk, Ponàr. Their education provided them with no shield, no shelter from the temptation and seduction of cruelty that people may carry within. Why? This question still haunts me.

It is impossible to study the history of German medicine during the Nazi period in isolation from German education in general. Who or what is to blame for the creation of the assassins in white coats? Was the culprit the anti-Semitic heritage that German theologians and philosophers were dredging up? The harmful effects of propaganda? Perhaps higher education placed too much emphasis on abstract ideas and too little on humanity. I no longer remember which psychiatrist wrote a dissertation demonstrating that the assassins hadn't lost their moral bearings: they knew how to discern Good and Evil; it was the sense of reality that was missing. In their eyes, the victims did not belong to humankind; they were abstractions. The Nazi doctors were able to manipulate their bodies, play with their brains, mutilate their future without remorse; they tortured them in a thousand ways before putting an end to their lives.

Yet inside the concentration camps, among the prisoners, medicine remained a noble profession. More or less everywhere, doctors without instruments or medications tried desperately to relieve the suffering and misfortune of their fellow prisoners, sometimes at the price of their own health or their own lives. I knew several such doctors. For them, each human being represented not an abstract idea but a universe with its secrets, its treasures, its sources of anguish, and its poor possibilities for victory, however fleeting, over Death and its disciples. In an inhumane universe, they had remained humane.

When I think about the Nazi doctors, the medical executioners, I lose hope. To find it again, I think about the others, the victim-doctors; I see again their burning gazes, their ashen faces.

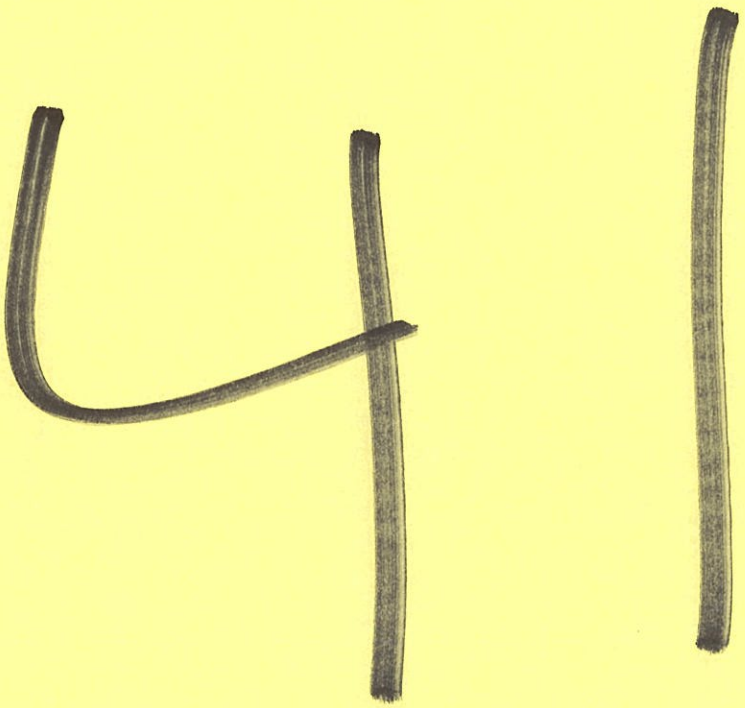
Why did some know how to bring honor to humankind, while others renounced humankind with hatred? It is a question of choice. A choice that even now belongs to us — to uniformed soldiers, but even more so to doctors. The killers could have decided not to kill.

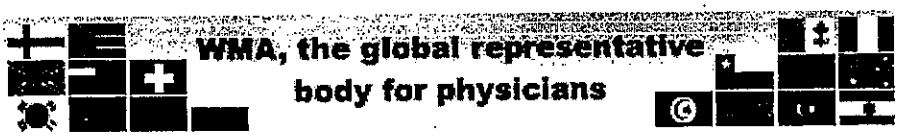
Yet these horrors of medical perversion continued beyond Auschwitz. Traces may be found, for example, in the hellish Stalin and post-Stalin eras. Communist doctors betrayed their brethren. Psychiatrists collaborated with the secret police to torture prisoners.

And how can the recent, shameful torture to which Muslim prisoners were subjected by American soldiers be justified? Shouldn't the prison conditions in Iràq have been condemned by legal professionals and military doctors alike?

Am I naive in believing that medicine is still a noble profession, upholding the highest ethical principles? For the ill, doctors still stand for life. And for us all, hope.

This article has been modified by the author from an essay in his collection *D'où viens-tu?* (Editions du Seuil, 2001) and was translated from the French by Jamie Moore.





Policy

THE WORLD MEDICAL ASSOCIATION REGULATIONS IN TIMES OF ARMED CONFLICT

Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956,
Edited by the 11th World Medical Assembly, Istanbul, Turkey, October 1957, and
Amended by the 35th World Medical Assembly, Venice, Italy, October 1983 and
The WMA General Assembly, Tokyo 2004

1. Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as established in the International Code of Medical Ethics of the World Medical Association. The primary obligation of physicians is to their patients; in performing their professional duty, their conscience should be their guide.

2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:

   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.

3. During times of armed conflict, standard ethical norms apply, not only in regard to treatment but also to all other interventions, such as research. Research involving experimentation on human subjects is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.

4. The medical duty to treat people with humanity and respect applies to all patients. The physician must always give the required care impartially and without discrimination on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing or any other similar criterion.

5. Governments, armed forces and others in positions of power should comply with the Geneva Conventions to ensure that physicians and other health care professionals can provide care to everyone in need in situations of armed conflict. This obligation includes a requirement to protect health care personnel.

6. As in peacetime, medical confidentiality must be preserved by the physician. Also as in peacetime, however, there may be circumstances in which a patient poses a significant risk to other people and physicians will need to weigh their obligation to the patient against their obligation to other individuals threatened.

7. 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.

8. 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.

9. Physicians have a duty to press governments and other authorities for the provision of the infrastructure that is a prerequisite to health, including potable water, adequate food and shelter.

10. Where conflict appears to be imminent and inevitable, physicians should, as far as they are able, ensure that authorities are planning for the repair of the public health infrastructure in the immediate post-conflict period.

11. In emergencies, physicians are required to render immediate attention to the best of their ability. Whether civilian or combatant, the sick and wounded must receive promptly the care they need. No distinction shall be made between patients except those based upon clinical need.

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Policy

World Medical Association Declaration of Tokyo. Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment

Adopted by the 29th World Medical Assembly Tokyo, Japan, October 1975

PREAMBLE

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

DECLARATION

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. 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 men, and no motive whether personal, collective or political shall prevail against this higher purpose.

5. Where a prisoner refuses nourishment and is considered by the doctor 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 decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

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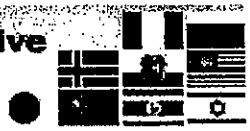

Policy

World Medical Association Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment

Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997

PREAMBLE

1. On the basis of a number of international ethical declarations and guidelines subscribed to by the medical profession, medical doctors throughout the world are prohibited from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.

2. Primary among these declarations are the World Medical Association's International Code of Medical Ethics, Declaration of Geneva, Declaration of Tokyo, and Resolution on Physician Participation in Capital Punishment; the Standing Committee of European Doctors' Statement of Madrid; the Nordic Resolution Concerning Physician Involvement in Capital Punishment; and, the World Psychiatric Association's Declaration of Hawaii.

3. However, none of these declarations or statements addresses explicitly the issue of what protection should be extended to medical doctors if they are pressured, called upon, or ordered to take part in torture or other forms of cruel, inhuman or degrading treatment or punishment. Nor do these declarations or statements express explicit support for, or the obligation to protect, doctors who encounter or become aware of such procedures.

RESOLUTION

4. The World Medical Association (WMA) hereby reiterates and reaffirms the responsibility of the organised medical profession:

   i. to encourage doctors to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task;

   ii. to support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures; and,

   iii. to extend its support and to encourage other international organisations, as well as the national member associations (NMAs) of the World Medical Association, to support physicians encountering difficulties as a result of their attempts to act in accordance with the highest ethical principles of the profession.

5. Furthermore, in view of the continued employment of such inhumane procedures in many countries throughout the world, and the documented incidents of pressure upon medical doctors to act in contravention to the ethical principles subscribed to by the profession, the WMA finds it necessary:

   i. to protest internationally against any involvement of, or any pressure to involve, medical doctors in acts of torture or other forms of cruel, inhuman or degrading treatment or punishment;

   ii. to support and protect, and to call upon its NMAs to support and protect, physicians who are resisting involvement in such inhuman procedures or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality;

   iii. to publicise information about and to support doctors reporting evidence of torture and to make known proven cases of attempts to involve physicians in such procedures; and,

   iv. to encourage national medical associations to ask corresponding academic authorities to teach and investigate in all schools of medicine and hospitals the consequences of torture and its treatment, the rehabilitation of the survivors, the documentation of torture, and the professional protection described in this Declaration.

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Policy

THE WMA DECLARATION OF WASHINGTON ON BIOLOGICAL WEAPONS

Document 17.400
Initiated: September 2001 17.400
Adopted by the WMA General Assembly, Washington 2002
Editorial Changes made during the May 2003 Council Session

A. INTRODUCTION

1. The World Medical Association recognizes the growing threat that biological weapons might be used to cause devastating epidemics that could spread internationally. All countries are potentially at risk. The release of organisms causing smallpox, plague, anthrax or other diseases could prove catastrophic in terms of the resulting illnesses and deaths compounded by the panic such outbreaks would generate. At the same time, there is a growing potential for production of new microbial agents, as expertise in biotechnology grows and methods for genetic manipulation of organisms become simpler. These developments are of special concern to medical and public health professionals because it is they who best know the potential human suffering caused by epidemic disease and it is they who will bear primary responsibility for dealing with the victims of biological weapons. Thus, the World Medical Association believes that medical associations and all who are concerned with health care bear a special responsibility to lead in educating the public and policy makers about the implications of biological weapons and to mobilize universal support for condemning research, development, or use of such weapons as morally and ethically unacceptable.

2. Unlike the use of nuclear, chemical, and conventional weapons, the consequences of a biological attack are likely to be insidious. Their impact might continue with secondary and tertiary transmission of the agent, weeks or months after the initial epidemic. The consequences of a successful biological attack, especially if the infection were readily communicable, could far exceed those of a chemical or even a nuclear event. Given the ease of travel and increasing globalization, an outbreak anywhere in the world could be a threat to all nations.

3. A great many severe, acute illnesses occurring over a short span of time would almost certainly overwhelm the capacities of most health systems in both the developing and industrialized world. Health services throughout the world are struggling to meet the demands created by HIV/AIDS and antimicrobial-resistant organisms, the problems created by civil strife, refugees and crowded, unsanitary urban environments as well as the increased health needs of aging populations. Coping over a short period of time with large numbers of desperately ill persons could overwhelm entire health systems.

4. Actions can be taken to diminish the risk of biological weapons as well as the potentially harmful consequences of serious epidemics whatever their origin. International collaboration is needed to build a universal consensus that condemns the development, production, or use of biological weapons. Programs of surveillance are needed in all countries for the early detection, identification, and response to serious epidemic disease; health education and training is needed for professionals, civic leaders, and the public alike; and collaborative programs of research are needed to improve disease diagnosis, prevention, and treatment.

5. The proliferation of technology and scientific progress in biochemistry, biotechnology, and the life sciences provides the opportunity to create novel pathogens and diseases and simplified production methods for bioweapons. The technology is relatively inexpensive and, because production is similar to that used in biological facilities such as vaccine manufacturing, it is easy to obtain. Capacity to produce and effectively disperse biological weapons exists globally, allowing extremists (acting collectively or individually) to threaten governments and endanger peoples around the world. Nonproliferation and arms control measures can diminish but cannot completely eliminate the threat of biological weapons. Thus, there is a need for the creation of and adherence to a globally accepted ethos that rejects the development and use of biological weapons.

B. STRENGTHENING PUBLIC HEALTH AND DISEASE SURVEILLANCE SYSTEMS

E. RECOMMENDATIONS

15. That the World Medical Association and National Medical Associations worldwide take an active role in promoting an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for prophylactic, protective, or other peaceful purposes.

16. That the World Medical Association, National Medical Associations and healthcare workers worldwide promote, with the World Health Organization, the United Nations, and other appropriate entities, the establishment of an international consortium of medical and public health leaders to monitor the threat of biological weapons, to identify actions likely to prevent bioweapons proliferation, and to develop a coordinated plan for monitoring the worldwide emergence of infectious diseases. This plan should address: (a) international monitoring and reporting systems so as to enhance the surveillance and control of infectious disease outbreaks throughout the world; (b) the development of an effective verification protocol under the UN Biological and Toxin Weapons Convention; (c) education of physicians and public health workers about emerging infectious diseases and potential biological weapons; (d) laboratory capacity to identify biological pathogens; (e) availability of appropriate vaccines and pharmaceuticals; and (f) financial, technical, and research needs to reduce the risk of use of biological weapons and other major infectious disease threats.

17. That the World Medical Association urge physicians to be alert to the occurrence of unexplained illnesses and deaths in the community and knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations.

18. That the World Medical Association encourage physicians, National Medical Associations and other medical societies to participate with local, national, and international health authorities in developing and implementing disaster preparedness and response protocols for acts of bioterrorism and natural infectious disease outbreaks. These protocols should be used as the basis for physician and public education.

19. That the World Medical Association urge all who participate in biomedical research to consider the implications and possible applications of their work and to weigh carefully in the balance the pursuit of scientific knowledge with their ethical responsibilities to society.

16.5.2003

[Introduction and history | Handbook]

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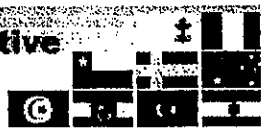

Policy

THE WORLD MEDICAL ASSOCIATION RESOLUTION ON THE RESPONSIBILITY OF PHYSICIANS IN THE DENUNCIATION OF ACTS OF TORTURE OR CRUEL OR INHUMAN OR DEGRADING TREATMENTOF WHICH THEY ARE AWARE

Initiated: September 2002
Adopted by the WMA General Assembly, Helsinki 2003

The World Medical Association,

1. Considering the Preamble to the United Nations Charter of 26 June 1945 solemnly proclaiming the faith of the people of the United Nations in the fundamental human rights, in the dignity and value of the human person,

2. Considering the Preamble to the Universal Declaration of Human Rights of 10 December 1948 which states that disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind,

3. Considering Article 5 of that Declaration which proclaims that no one shall be subjected to torture or cruel, inhuman or degrading treatment,

4. Considering the American Convention on Human Rights adopted by the Organization of American States on 22 November 1969 and which entered into force on 18 July 1978 and the Inter-American Convention to Prevent and Punish Torture, which entered into force on 28 February 1987,

5. Considering the Declaration of Tokyo, adopted by the WMA in 1975, which reaffirms the prohibition of any form of medical involvement or presence of a physician during torture or inhuman or degrading treatment,

6. Considering the Declaration of Hawaii (World Psychiatric Association), adopted in 1977,

7. Considering the Declaration of Kuwait (International Conference of Islamic Medical Associations), adopted in 1981,

8. Considering the 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, adopted by the United Nations General Assembly on 18 December 1982, and particularly Principle 2, which states: "*It is a gross contravention of medical ethics... 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...*",

9. Considering the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on December 1984,

10. Considering the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which was adopted by the Council of Europe on 26 June 1987 and entered into force on 1 February 1989,

11. Considering the Resolution on Human Rights adopted by the WMA in Rancho Mirage, in October 1990 during the 42nd General Assembly and amended by the 45th, 46th and 47th General Assemblies,

12. Considering the Declaration of Hamburg, adopted by the WMA in November 1997 during the 49th General Assembly and calling on physicians to protest individually against ill-treatment and on national and international medical organizations to support physicians in such actions,

13. Considering the Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), adopted by the United Nations General Assembly on 4 December 2000,

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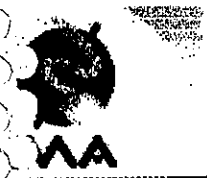

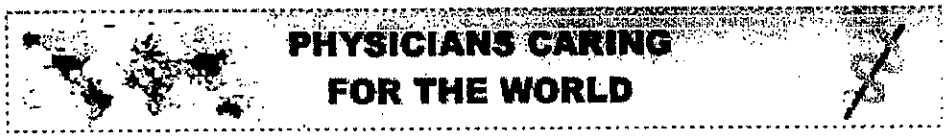

Press Releases

Latest releases: 9 October 2004

Physicians' ethical Duty in Times of armed Conflict reiterated

The medical duty on all physicians to treat people with humanity and respect in times of armed conflict has been reiterated by the World Medical Association at its annual General Assembly in Tokyo.

WMA delegates from 40 countries agreed to amend the organisation's policy on physicians' ethical behaviour to emphasise that medical ethics in times of armed conflict are identical to medical ethics in times of peace.

The policy clearly states that it is unethical for physicians to give advice or perform procedures that are not justifiable for the patient's health care or that weaken the physical or mental strength of a human being without therapeutic justification.

The WMA's policy declares that research involving experimentation on human subjects is strictly forbidden on all people deprived of their liberty, especially civilian and military prisoners and the population of occupied countries. The physician must always give the required care impartially and without discrimination on the basis of creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing.

The policy also declares that governments, armed forces and others in positions of power should comply with the Geneva Conventions to ensure that physicians and other health care professionals can provide care to everyone in need in situations of armed conflict. Physicians must be granted access to patients, medical facilities and equipment and the protection needed to carry out their professional activities freely.

Commenting on the amended regulations, Dr Yoram Blachar, chairman of the WMA Council, said: 'In today's world it is more important than ever that physicians recognise their ethical responsibilities in times of armed conflict. They are often faced with enormously difficult situations and I hope that these guidelines will help them abide by the highest ethical standards of the medical profession'.

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A LOOK AT . . . Releasing Serial Killers; We're Doctors--Not Judges, Juries or Jailers; [FINAL Edition]

Howard Zonana. **The Washington Post**. Washington, D.C.: Dec 5, 1999. pg. B.03

Full Text (1094 words)

Physicians who promote the extension of sexual predator statutes, or even endorse them, must have lost their moral compass. It is not hard to understand the public's wish to see repeat offenders locked up and prevented from inflicting further harm upon society. The public probably couldn't care less whether the confinement is in a prison or a mental hospital, though people might have a few qualms if they understood that the hospital costs are two to five times higher.

It is harder to understand, however, why physicians would be willing to use their medical authority for preventive detention and punishment. Involuntary hospitalization was designed to ensure that those who are seriously mentally ill receive humane care and treatment when they are unable to care for themselves. It was not designed to be an arm of the criminal justice system.

Recently, some states have created a new kind of civil commitment that permits a class of criminals--repeat sexual offenders--to be transferred at the end of their sentences from prisons to hospitals and detained there until they can prove they are no longer dangerous. The decision to commit can be made on the basis of the behavior that resulted in their original arrest. No evidence of recent dangerous behavior is required. The laws are so broad as to include exhibitionists as well as sexual sadists and other criminals, as long as there was a sexual component to the crime. Now, some justice and mental health officials want to extend this to certain murderers so that they, too, would be indefinitely confined under the label of "mentally abnormal."

Because the element of mental abnormality is so vague, it allows the state to select the criminal behavior it would like to target and then find some disorder that will be present in certain felons. It is not that it is impossible to diagnose potentially dangerous mental abnormalities; it is that the process is an abuse of psychiatry.

About 15 states have adopted these "sexually violent predator" commitment statutes, upheld in 1997 as constitutional by a 5-to-4 U.S. Supreme Court decision in Kansas v. Hendricks. Leroy Hendricks is a pedophile who was arrested and imprisoned several times for molesting children. After he had finished serving his time--and although he had consistently been found legally sane and competent-- he was sent to a state hospital for the criminally mentally ill based on his mental disorder of pedophilia and presumed continuing inability to control his behavior. This amounts to using physicians and the mental health system to extend a criminal's prison sentence indefinitely.

Repeat sex offenders have always outraged the public. In an earlier era of therapeutic optimism--roughly the 1940s and '50s-- more than half the states had laws confining such criminals to hospitals instead of prisons so that they could obtain treatment. When treatment did not work well enough, most states repealed or suspended these statutes and used "indeterminate" sentences such as "one day to life" to keep such offenders in prison.

But in the '70s, sentencing reforms repudiated a system that could be so prone to abuse. It was replaced with "determinate sentencing," wherein convicted felons receive fixed sentences and are required to serve the entire time in prison.

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Is It Ethical for Psychiatrists to Participate in Competency-To-Be-Executed Evaluations?

Point *by Paul S. Appelbaum, M.D.*

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In its 1986 decision in *Ford v. Wainwright,* the U.S. Supreme Court found that death row prisoners had a constitutional right not to be executed if they were incompetent (477 U.S. 399 [1986]). Competence for execution-an odd concept, but one whose roots go back to biblical times-usually requires that a prisoner understand the nature of the punishment about to be imposed and why it is being imposed.

Dr. Lawrence Hartmann and I differ on whether it is ethical for a psychiatrist to evaluate a prisoner whose competence has been questioned. In my view, such an evaluation-which may result in saving the prisoner's life-is an ethical act. Indeed, failure to conduct the evaluation, which may be tantamount to condemning the prisoner to execution, may be unethical.

Psychiatrists and other physicians, of course, have been involved for centuries in performing evaluations for the courts and offering testimony. These activities encompass civil issues (e.g., disability, emotional harms, parental fitness), as well as criminal issues (e.g., competence to stand trial, criminal responsibility, aid in sentencing). This involvement with the courts is generally recognized as advancing the pursuit of justice and, as such, an entirely praiseworthy function. Competence for execution evaluations would appear to implicate the same goals-providing expertise to help the courts with critical determinations.

In fact, both the American Medical Association's Council on Ethical and Judicial Affairs and the American Psychiatric Association's Committee on Ethics have agreed with this conclusion. As the AMA put it, "without physician participation, individuals might be punished unjustifiably." To conclude

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Is It Ethical for Psychiatrists to Participate in Competency-To-Be-Executed Evaluations?

Counterpoint *by Lawrence Hartmann, M.D.*

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What counts as participation in capital punishment? Is it possible for a medical activity to be ethical in one context, but a similar one not ethical in another? Is death different? Are there neat and universal ethical rules that will always guide us wisely, or are there inevitable clashes among various legitimate and important values? Is it ethically possible that a forensic psychiatrist is not a psychiatrist, as Dr. Paul Appelbaum has argued? How strongly should physicians protect their duty to always help and not harm all individual patients in the face of many pressures to do otherwise?

All these questions bear on the current debate as to whether it is ethical for a psychiatrist to perform a competency-to-be-executed evaluation.

My position (a widespread and traditional position [Freedman and Halpern, 1996], is that it is not ethical. Alfred Freedman, M.D., and I argued this point against Paul Appelbaum, M.D., and Ken Hoge, M.D., at the American Psychiatric Association annual meeting last May. Internationally, as evidenced by the positions of the World Medical Association, the World Psychiatric Association, the British Medical Association and others, the position still prevails that it is not ethical. However, Appelbaum and others led an important movement to change this in the mid-1990s, and succeeded in getting a significant and even radical shift of position in the APA Council on Psychiatry and Law, and the APA itself. I find that shift disturbing and interesting. This debate now probably reflects a significant division of opinion among American psychiatrists, and the issues involve some subtlety and facing of value conflicts (Rothstein, 1995).

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The Foreign Intelligence Surveillance Act: Law Enforcement's Secret Weapon

Leslie Danoff

J Am Acad Psychiatry Law 28:213–24, 2000

On the sixth floor of the U.S. Justice Department is a secret courtroom. Although this special court, with its own set of rules, has been in existence for 20 years, most Americans have never heard of it. Even most of the lawyers who work at the Justice Department do not know that this court is there, much less what it does. Created in 1978 by the Foreign Intelligence Surveillance Act (FISA), the FISA (rhymes with surprise-yah) court permits the government to conduct electronic surveillance and searches in ways the framers of the Constitution would never have imagined. It authorizes the government to ferret out the most intimate details about its citizens' psychiatric vulnerabilities, including eavesdropping on conversations between psychiatrist and patient. The unchecked power of the government and lack of due process legitimized by this statute are unlike anything else in the American judicial system.

Although the jury never heard the word "FISA," this statute played a major role in what may be the last espionage trial of the Cold War. The defendants, Theresa Squillacote and her husband, Kurt Stand, were convicted of espionage in Alexandria, Virginia's Federal Courthouse on October 23, 1998. They were sentenced on January 22, 1999—Squillacote to 21 years and 10 months, Stand to 17.5 years.

Parents of Karl, 16, and Rosa, 14 (named for Karl Liebknecht and Rosa Luxemburg, founders of the German Communist Party who were killed in an unsuccessful revolt in 1919), the couple had been charged with 25 years of spying—for East Germany, the Soviet Union, Russia, and South Africa. (A friend indicted with them, James Clark, pleaded guilty and received a 12-year sentence.)

Until she impulsively quit her job when her boss resigned in January 1997, Terry Squillacote, 42, had been a Pentagon lawyer in the Acquisition Reform Department. A model government worker, she was presented with a Reinventing Government Award by Vice-President Al Gore in 1996 for her innovative efforts to reform the Defense Department's procurement process. She had received a secret security clearance in April 1992. (Half a century earlier, her mother was involved in the most sensitive national security secret in history. An undergraduate chemistry student of Enrico Fermi at the University of Chicago, she was assigned to the Manhattan Project and helped to develop the casing for the atomic bomb.)

Kurt Stand, 45, who worked for a labor union, developed his political ideology at an early age. His German immigrant parents resisted the rise of Hitler and left for the United States shortly before World War II. Kurt's father enlisted in the U.S. Air Force and fought against Germany. Concerned, after the war, that the new West Germany was too militant and that there were too many former Nazis in its government, Kurt's parents were openly supportive of East Germany. His father was fired from his factory job for his pro-Communist views.

The Federal Bureau of Investigation (FBI) opened its first file on Kurt when, as a student at Stuyvesant High School in New York City, he visited the Soviet Mission to the United Nations to collect information for a research project. When Kurt left the building,

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essary to achieve its purpose, or for ninety days, whichever is less [FISA, § 1805]."

FISA intercepts, like Title III intercepts, are supposed to be minimized. "Minimization," as defined by FISA, is "designed to limit the acquisition, retention, and dissemination of information that is not foreign intelligence information and which relates to United States citizens or permanent resident aliens [Legislative History, P.L. 95–511, Foreign Intelligence Surveillance Act of 1978, p. 3938]." Congress had noted the courts' approval of minimization: "It is . . . obvious that no electronic surveillance can be so conducted that innocent conversations can be totally eliminated [Legislative History P.L. 95–511, p. 3938]." It was the government's obligation, however, to reduce privacy intrusions by disregarding and eliminating information that has nothing to do with foreign intelligence.

Squillacote and Stand's lawyers believe that the FISA secret searches and surveillance directed against their clients were illegal, violating the minimization provisions of FISA as well as the First and Fourth Amendments of the U.S. Constitution. However, their request to U.S. District Court Judge Claude Hilton for an opportunity to view the FISA affidavits, the foundation of the government's case, was denied.

The defense team (which includes former Justice Department attorneys) had received top security clearances. Despite these credentials, the government maintained that its intelligence "sources and methods" would be compromised if defendants' lawyers were allowed to see, for example, the evidence that had convinced the FISA court there was probable cause that the couple were "agents of a foreign power" in late 1995 or early 1996—when the first of an estimated 18 FISA applications were presented to the secret court.

Lawrence Robbins, Squillacote's lead attorney, bristles at the government rationale that allowing access to these documents could provide a road map for spies. "In cases where the lawyers all have security clearances," he contends, "it's indefensible to be refused access to FISA affidavits. The irony is, by the time the case was over, we had been shown by the government vastly more sensitive information than any that could possibly have been in the FISA affidavits."

The district court judge was persuaded, however, by the government's claim that "no court charged with determining the legality of a FISA surveillance has granted discovery of FISA applications and related materials or a hearing to a target"; and that "applications for the surveillances and searches [of Squillacote and Stand] had been approved by eight different FISA Court judges."

Robbins (in private practice at Mayer, Brown, and Platt in Washington, DC), lead attorney for the defense, explains:

> The FISA statute has become, over time, the worst sort of Catch-22. Because no defense counsel has ever been shown an affidavit, none has been able to successfully challenge probable cause. Because no one has ever successfully challenged probable cause, the government can come into court and tell the trial judge, "don't show these lawyers the affidavit, because no court has ever done that before." Before you know it, this string of victories, secured without the slightest semblance of effective opposition by defense counsel, is held out as the very reason to rule against the defense once again. There is simply no way for defense counsel to do their job. The rights established by the statute are utterly hollow. They may as well be repealed [interview, Nov. 1998].

Since the adversarial process does not apply to FISA, and a judge has never once, in two decades, found merit in a defense challenge, it is not surprising that a FISA order is law enforcement's warrant of choice. (In the decade between 1987 and 1997, for example, 6633 FISA wiretaps and searches were authorized compared with 4,545 federal Title III intercepts.)

Nevertheless, eight months into its FISA investigation of Squillacote and Stand, the FBI had turned up no evidence that they were passing classified information. According to an internal memorandum of the FBI Washington field office dated August 6, 1996, the Bureau had yet "to determine the extent of subject's [Squillacote's] involvement with the former East German Intelligence Service (EGIS) and the current Russian Intelligence Service . . . WFO [Washington field office] cannot yet say what classified information has been compromised nor the true nature of subject's access to that information." It was not for lack of effort. The FBI had placed a microphone in the couple's home; they were well into the process of taping 550 days of phone calls and had searched their house. (Fifty agents conducted one of the three searches, which lasted for six consecutive days.) They had sifted through the family trash and bugged Terry's telephone at her Pentagon office.

Although this comprehensive surveillance had not demonstrated that the couple had transmitted any classified national security information, the FBI had

allowed to stay through the night, sitting in a chair next to the child's bed.) There were no semi-private or private rooms. Children such as Terry were, instead, assigned to large wards. Among several dozen other frightened, suffering children, Terry heard their anguished cries blending with her own. It was difficult for a child to separate the screaming of the others from her own considerable pain.

Terry recalls "being absolutely terrified that I had to be totally obedient, or else something awful would happen. I also remember it being drummed into me that no matter how much I hurt, someone else was always suffering more. . . . I remember once when I was somewhat older and was having a bone spur removed from my stump, some machine that was circulating the blood from one part of my leg to another jammed up. The pain was unbearable. I couldn't even cry. It was like stepping into a blast of freezing air; your eyes dry up and teeth hurt. Mom had stepped out to go to the cafeteria. The mother of the little girl next to me was so upset for me. She kept trying to cheer me up with some little purple stuffed animal. And all I could think of was how badly she felt, and that I should try to smile to make her feel better."

Terry's father, aloof and unavailable, very much expected his youngest daughter to find a way to be a high achiever like her parents. Her mother, guilty about having a deformed child who had to undergo so much pain, treated Terry as the favored child. Dr. Eric Plakun, a psychiatrist with the Austin Riggs Center in Stockbridge, Massachusetts, met with Terry over a four-month period while she was awaiting trial. As a defense expert, he testified that the mother became very close to Terry and "let her get away with things, feeling that some kind of transgressions could be overlooked because of what she had been through. . . . Some of this got transmitted to Theresa in her sense of entitlement that is part of her narcissism. 'For what I have endured, I ought to be given some reward.' And, in fact, as she was growing up, she became engaged in a certain amount of shoplifting that had to do with this sense of, 'I am entitled to something to make up for what has happened to me.'"

The BAP team's presentation and analysis of Terry Squillacote's history is detailed in an extraordinary classified document, dated August 16, 1996, that her lawyers were able to obtain through discovery. The movie, *Silence of the Lambs*, gave Squillacote's attorney, Lawrence Robbins, the idea to ask the government prosecutor whether the FBI had prepared a psychological profile of his client. The prosecutor informed Robbins that such a document existed; although it was classified, the defense attorneys were allowed to read it. Subsequently, a Justice Department official who reviews classified documents agreed to consider declassifying this BAP report. She assured the defense lawyers that their submission would "be walled off from the other side" during the review process. Virtually the entire document was released, with the exception of the name of the psychologist who prepared it.

The BAP report provides a rare window into how the government can use its vast powers to entrap a psychologically vulnerable target. Among the intelligence findings in the BAP team's 14-page blueprint for its sting were the following:

> LS [Loftiest Shade, the code name the FBI assigned to Squillacote] walks with a limp due to her prosthetic right limb. She flaunts her handicap by wearing clothing that highlights her limb, and she takes offense when someone makes a joke about handicapped people. She suffers from cramps and depression and is taking the anti-depressants Zoloft and Diserel. She may also be using marijuana and cocaine. The subject's family has been beset with depression: her mother was prone to depression; her sister committed suicide; and her brother is taking anti-depressants.
>
> When she feels as though she is losing control and is under stress (which is the majority of the time), she becomes hysterical, sobs, and screams. When she has been under a great deal of stress, she has reported that she has the sensation of falling off a cliff.
>
> This person reflects a cluster of personality characteristics often loosely referred to as "emotional and dramatic." She needs constant attention and approval. She reacts to life events in a dramatic, over-emotional fashion, calling attention to herself at every opportunity. . . . She is totally self-centered and impulsive.
>
> The subject has been in a state of grief and "hurt" since her handler cut off their relationship. She compared the ending of this relationship to the death of her mother. In addition, there are several instances in which she has referred to her husband as "Daddy."
>
> She will likely grieve for about one year for her "lost" (former) East German contact. This is an important time period in which it is possible to take advantage of her emotional vulnerability.
>
> The type of UCA [undercover agent] who approaches her will be very important. She will respond to a "type of person who possesses the same qualities of dedication and professionalism as her last contact (although probably not necessarily any physical resemblance) . . . . The new contact will provide some

good person there, she could be a genius. Without that person, she thought, 'I'm nothing, I'm empty, alone, abandoned.'"

Dr. Janofsky concurred with Dr. Plakun, concluding that Terry's early history of protracted hospitalizations had left her with an intense fear of abandonment. In his interviews with Squillacote, the two discussed "how difficult that was for her to be alone in the hospital without her mother or father . . . suffering, multiple times." As a result of these experiences, Janofsky concluded that Terry would make extraordinary efforts "to avoid real abandonment or imagined abandonment." As he put it, "the impending separation or rejection can lead to a profound and quite a remarkable change in self-image, mood, thinking and behavior."

While the FBI designed the undercover operation, the agents were fully aware of Terry's fear of abandonment as well as the cumulative impact of more than a decade of personal losses: her mother's death, her sister's suicide, her son's encephalitis, her husband's failure to achieve the kind of greatness she'd envisioned, her father's recent cancer diagnosis. And of course, the loss of Ziemer. "The subject has been in a state of grief and 'hurt' since her handler cut off their relationship." Now is the best time, the agents concluded, to exploit that weakness.

> Because LS seems to crave excitement in her life, a personal false flag approach should be used against the subject. This may be initiated by placing a letter in her own post office box from the object of her adulation in South Africa who will tell her he is sending a personal emissary from the South African Intelligence Service to visit her. The letter could indicate that LS is to meet her handler in New York City for the weekend.
>
> The letter could state that the meet will take place at the Waldorf-Astoria Hotel in Manhattan. She should be instructed to travel a circuitous route to New York City from Washington, D.C. This should add a sense of excitement and intrigue to the scenario.

Terry received the FBI's letter on September 25, 1996. Her psychiatrist, Dr. Apud, described her psychiatric condition through September 19 as "still depressed. The pervasive maladaptive behaviors were still there." Dr. Apud's next session with Terry was on September 28. His notes reflect that she seemed happy, had a full range of affect, was verbal, coherent, pleasant. She reported that she was sleeping better and asked whether they might decrease the frequency of the sessions. Since Dr. Apud "couldn't find any particular thing from our conversation that could explain this sudden change of affect, my first thought was that she was becoming manic."

What Terry's psychiatrist didn't know was that she was responding to the FBI's overture just as the BAP team had predicted. The fake letter from the South African Defense Minister begins: "Greetings to you from afar. I hope this note finds you well in body and spirit. I think of you whenever I look at your letter of last year. It helps me put aside the necessary tedium with which I must deal these days and refocus on truly important matters. Thank you again for this gift."

Dr. Plakun, during direct examination, described the initial paragraph as "catering to [Squillacote's] narcissism. A sense that halfway around the world a man, who really in her eyes is a celebrity, thinks of her often, goes back and rereads her letter, and that she exists in his mind."

The flattery comes at a time when Terry "is frantic about having been abandoned by the father figure, prosthetic human, the artificial leg of a human being that she needs psychologically. And suddenly here is this person halfway around the world who considers her writing and her contributions brilliant. This caters to her sense of specialness, to her fantasies of being unique, to her grandiose sense of having something to contribute."

The concluding paragraph reads: "My representative can more securely sustain this important dialog. In time, I hope we can meet, share some time, and reflect upon our experiences over a drink. Until then, good luck and my profound gratitude."

Dr. Plakun explained to the jury that "there is a promise of a personal connection some day with this man who is a celebrity in [Squillacote's] eyes, catering to her sense of self-importance and grandiosity and specialness, and a transferring of his authority to the undercover agent."

FBI Special Agent Douglas Gregory, a member of the BAP team and 23-year veteran of foreign counterintelligence, was tapped for the role of the South African emissary. To prepare for the part, the tall, dark-haired, bespectacled Gregory wrote a detailed script:

> Why don't you call me "Robert" (wink). . . . It's not everyday someone like you knocks on our door asking to help. . . . I could tell within a few minutes of meeting you that you are quite different. I'm really enjoying this conversation. . . . Don't sign your real name to any message. Tonight why don't you select a special name to use for this purpose. It can be anything you want it to be. . . Obviously, it would be best to keep our relationship

GW *et al.* New York: McGraw-Hill, 1977) that "a thorough history and exam of the patient are fundamental to psychiatric diagnosis," he nevertheless did not meet with Terry Squillacote in preparation for his testimony: "There are some controversial aspects of the Code of Ethics in the American Academy of Psychiatry and the Law, particularly as it relates to the issues of examining people before rendering an opinion. And I disagree with that one. . . . the issue of interviewing an individual is not essential to rendering an opinion."

While the defense experts countered the government's suggestion that Terry had been "predisposed" (even before the government approached her) to commit the offenses, the jury was not persuaded. "Agent Gregory was very professional. I think he did his job. I'm glad we have people like him protecting the country," said one juror.

Some 20 years ago, the FISA sponsors had envisioned that their new law would provide a very different kind of protection. Senator Edward Kennedy, in 1977, described his objective in sponsoring FISA as a desire to "reach some kind of fair balance that will protect the security of the United States without infringing on our citizens' human liberties and rights."

How did FISA—which is so at odds with the Fourth Amendment right of Americans "to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures"—come to be? Ironically, its drafters thought they were doing a good thing, curing, not authorizing, the abuse of civil liberties by domestic law enforcers.

By the mid-1970s, the need to do something about illegal domestic spying was undeniable. President Gerald Ford's Attorney General, Edward Levi, was confronted with the precarious state of Fourth Amendment protections during his very first afternoon on the job. An FBI agent came to his office, unannounced.

According to Levi, the agent "put before me a piece of paper asking my authorization for the installation of a wiretap without court order. He waited for my approval." The agent was surprised when, instead of signing the document, Levi showed him the door. As a law professor and Dean of the University of Chicago Law School, the new Attorney General had taught his students that only judges had the power to sign warrants for electronic surveillance. Yet, even in the post-J. Edgar Hoover, post-Watergate eras, that was not law enforcement's standard operating procedure.

At the same time that Attorney General Levi was receiving his initial on-the-job training, the Senate Intelligence Committee, chaired by Senator Frank Church of Idaho, was disclosing illegal government spying on a grand scale, spanning nine Administrations. Richard Nixon's spying operation was merely the most recent and perhaps most egregious example. (Presidents had always asserted "inherent power" to conduct warrantless surveillance in the name of national security; and neither the Supreme Court nor Congress had contradicted or circumscribed this presidential claim.) While the sheer number of people targeted during the Nixon years may have exceeded those of previous administrations, Congress concluded that the illegal taps and break-ins occurring under Nixon's watch "were regrettably by no means atypical."

The Church Committee reported that "Since the 1930s, intelligence agencies have frequently wiretapped and bugged American citizens without benefit of judicial warrant. . . . The inherently intrusive nature of electronic surveillance . . . has enabled the Government to generate vast amounts of information unrelated to any legitimate government interest—about the personal and political lives of American citizens."

Congress was particularly appalled by the revelations of the FBI's counterintelligence program, known by the acronym COINTELPRO. It was directed at anyone whom the Bureau, at the whim of J. Edgar Hoover, had deemed an undesirable or subversive person. In Hoover's secret vendetta against Martin Luther King and the civil rights movement, for example, FBI agents had performed numerous "black bag jobs" (illegal burglaries) and illegal wiretaps. The FBI's unambiguous goal was to "neutralize" King, one of its perceived enemies of the state, and destroy his movement.

How was the government to prevent future abuses in the name of national security while still protecting *bona fide* national security interests?

The Supreme Court was grappling with this question. In the Keith case, decided in 1972, the Court acknowledged the long-standing Justice Department policy of warrantless electronic surveillance. It recognized the "elementary truth" that "unless Government safeguards its own capacity to function and to preserve the security of its people, society itself could

informing Americans that their homes and papers have been searched."

The Clinton Justice Department argued that FISA searches would offer greater protection to individual liberties. If Presidents had unfettered inherent authority to conduct warrantless physical searches for foreign intelligence purposes (if it was something they were going to do anyway), wouldn't civil liberties interests be better served if the Executive voluntarily deferred this power to the FISA court?

Testifying on July 14, 1994, Deputy Attorney General Jamie Gorelick identified the "need to strike a balance that sacrifices neither our security nor our civil liberties."

That had also been the mantra when the original FISA was debated. However, it has been impossible to achieve this balance because the law's procedural protections have never been implemented. Congress, according to FISA's legislative history, intended the statute to provide "twin safeguards of an independent review by a neutral judge and the application of a 'probable cause standard.'" Expecting that not all FISA applications would pass muster, the law provided a review process. If the FISA court judge said "No" to the government lawyer, an appeal to one of the other six judges was not to be permitted. That would be the province of a three-judge court of review, also appointed by the Chief Justice.

This review panel has never met. In 1995, three years before his death, Judge Robert Warren, Senior U.S. District Judge in Milwaukee, described his tenure on the FISA Court of Review. It began in 1989 when "I was sent a designation by the Chief Justice, and I asked a couple of people what in the world the court did because I had not even heard of it before I got that designation. I also had some correspondence with my brethren on the Court and we've talked to each other and said, 'What are we supposed to do? And, 'When is something going to happen?' Nothing ever has happened. It's an empty title as far as I am concerned at this point.'"

There is a simple explanation for the FISA Court of Review's lack of a mission. FISA applications are universally granted. Between 1979 and 1998, 11,211 orders were granted. During those two decades, just one was denied. This near-perfect score suggests that the FISA court may merely be a "rubber stamp" for the government. Fran Fragos Townsend, the Director of the Justice Department's Office of Intelligence Policy and Review (OIPR), which prepares and reviews all FISA applications, takes exception to this characterization. She maintains that her office's awesome wining streak before the FISA Court is, instead, a reflection of the care with which each application is prepared and the scrutiny it receives from the FISA judge: ". . . it's not right to conclude that the government's track record in getting FISA applications approved means that the FISA court is a rubber stamp. . . . When FISA judges believe that an application is deficient, they generally permit the government to withdraw the application to amend it or even do more investigating, rather than simply rejecting it."

But only a few years ago, a career federal prosecutor, asked by Attorney General Janet Reno to conduct an internal investigation of the OIPR, uncovered major problems. Richard Scruggs, an Assistant U.S. Attorney in Miami, was working in Washington, DC, as a special assistant to the Attorney General when he began this assignment at the end of 1993. He found "there were so many FISAs being conducted with so few attorneys that the review process to prevent factual and legal errors was virtually nonexistent." At the time he initiated his inquiry, over 7,500 FISA orders had already been granted.

How many of the FISA orders in the last two decades have been targeted at Americans suspected of being "agents of a foreign power"? The 1978 statute did not ask the Justice Department to supply this information to Congress. It did require, however, that each April, the Attorney General would send a report to Congress and the Administrative Office of the United States Court reporting the total number of applications for electronic surveillance as well as how many were either granted, modified, or denied. The annual half-page letter containing that information is publicly available.

The "Congressional Oversight" section of the 1994 FISA Amendment imposed the disclosure requirement that physical searches be reported semiannually to Congress. In addition to "the total number of applications made for orders approving physical searches under this chapter," the Attorney General is to specify "the number of physical searches which involved searches of the residences, offices, or personal property of United States persons."

Starting with the Attorney General's 1996 terse, two-paragraph summary, the number of physical searches has been subsumed within the total of electronic surveillance applications. No breakdown of the two distinct foreign intelligence-gathering meth-

The Ethical Use of Psychology in Criminal Investigations

Special Agent John R. Schafer, MA

J Am Acad Psychiatry Law 29:445–6, 2001

This commentary responds to an article by Leslie Danoff titled, "The Foreign Intelligence Surveillance Act: Law Enforcement's Secret Weapon," published in the *Journal of the American Academy of Psychiatry and the Law*.[1] According to Danoff, the Federal Bureau of Investigation (FBI):

> . . .determined that it was time to launch a "sting." A select group of FBI agents, known as the Behavioral Assessment Program (BAP) team met on June 20, 1996, with a Ph.D. psychologist-consultant to discuss how best to exploit Terry's [Squillacote] severe emotional distress.

The FBI's undercover operation yielded sufficient evidence to arrest Squillacote, her husband Kurt Stand, and friend James Clark for espionage. Clark pleaded guilty and received a 12-year prison sentence. In October 1998, a Virginia jury convicted Squillacote and Stand for violation of 18 U.S.C. § 794(a) and (c), "conspiracy to transmit information relating to the national defense"; 18 U.S.C. § 794(a), "attempted transmission of national defense information"; and 18 U.S.C. § 793(b), "obtaining national defense information." Squillacote alone was also convicted under 18 U.S.C. § 1001, "making false statements." In January 1998, a federal judge sentenced Stand to 17 years, 6 months in prison and Squillacote to 21 years, 10 months.

Squillacote and Stand appealed their convictions to the Fourth Circuit Court of Appeals. They argued:

> . . .the FBI, through its BAP report profiling Squillacote, masterfully catalogued Squillacote's every emotional and psychological vulnerability. The FBI then used this information to devise an undercover operation exploiting these weaknesses to ensure that Squillacote would fall for the undercover agent's pitch.[2]

Squillacote's and Stand's attorneys further argued that the undercover agent "induced Squillacote into going along with his scheme by making subtle psychological appeals to which he knew Squillacote could be uniquely vulnerable."

The appeals court upheld the convictions of Squillacote and Stand and ruled in part that:

> [t]*he government's evidence established that Squillacote's involvement with the HVA [East Germany's Intelligence Service] went back almost twenty years.* Through her East German contacts, Squillacote learned how to determine if she was being followed and how to evade those who might be following her, how to receive and decipher sophisticated coded messages, how to use the miniature document camera, how best to remove any "classified" markings on documents. After the fall of East Germany, when Squillacote finally had a job that gave her access to sensitive information, *Squillacote herself sought out opportunities to use these skills.* She contacted David Truong, a convicted spy, in the hopes of establishing a new "connection," and she sent her fan letter to Kasrils, the South African official, hoping that he would "read between the lines." *That Squillacote actively sought employment as a spy is powerful evidence that she was disposed to committing espionage well before the government first contacted her*[2] (emphasis is the author's).

Squillacote and Stand appealed to the U.S. Supreme Court for relief. However, the Court declined to hear the case.

Jeffery Janofsky, a psychiatrist with The John Hopkins University School of Medicine, Baltimore, MD, testifying as an expert defense witness at Squillacote's and Strand's criminal trial, charged the FBI's psycholo-

Special Agent (SA) Schafer is assigned to the resident office of the Federal Bureau of Investigation, Lancaster, CA, and has extensive experience in espionage and other criminal violations. SA Schafer was not involved in the Squillacote investigation. The views expressed herein are those of SA Schafer and not the opinion of the FBI or of the Behavioral Analysis Program. Address correspondence to: SA John R. Schafer, Federal Bureau of Investigation, PO Box 4786, Lancaster, CA 93539. E-mail: akajack@earthlink.net

Reply to Schafer: Defending the Facts

Leslie Danoff

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Despite the promising title of his article, Special Agent (SA) John Schafer neglects to describe, explore, or otherwise illustrate "The Ethical Use of Psychology in Criminal Investigations." I would not disagree that such an argument can be made. But he does not make it. Instead, he criticizes what appears to him to be a sympathetic portrait of two traitors. My article did not take a position on the general subject of the ethical uses of psychology in criminal investigations. I did, however, suggest that the involvement of a psychologist in planning the undercover operation against Theresa Squillacote raises compelling questions of ethics:

> Should a professional trained to heal instead use his or her expertise to devise an undercover blueprint that is likely to result in harm?... On the other hand, since the psychologist who advised the FBI did not have a therapeutic relationship with Squillacote, is he governed by conventional ethical constraints? It is hardly unprecedented for professionals with psychological training to assist law enforcement officers in ferreting out suspected wrongdoers.[1]

The declassified plan of the Behavioral Assessment Program (BAP), which my article presents in detail, indeed strongly supports the conclusion that an ethical line was crossed in the preparation and execution of one specific operation against one specific individual.

Squillacote had had a secret security clearance since April 1992. Yet, as late as August 1996, after intense and ongoing surveillance, the Federal Bureau of Investigation (FBI) had gathered no evidence that Squillacote or her husband Kurt Stand had passed classified information. Although three searches of their house and telephone taps at her home and office for approximately a year and a half had failed to yield a "smoking gun," the government surveillance had resulted in amassing a huge amount of very private, very personal information on a deeply psychologically disturbed woman—much more than her psychiatrist possessed. Would it have been prudent for the BAP team to consider the ethical implications of using the details of her severe mental illness to develop their extremely potent plan? Having expressly noted that "it is possible that once she has been arrested she will make a suicide attempt" (Ref. 1, p 218), did they ponder the potential consequences of what they were about to do to a United States citizen? Defense lawyer Richard Sauber asked the FBI's SA in the case, Douglas Gregory, whether anyone at the BAP team meeting had ever said:

> "We have been at this for a long time, we haven't found anything, let's just get her fired from her job at the Pentagon."
>
> Gregory responded, "That's not the role of the BAP Team. . . . No, nobody said that."
>
> Sauber: "Did anyone at the BAP raise concerns about proceeding with such a sting operation if it might result in a death of a target?"
>
> Gregory: "No."
>
> Sauber: "Okay. Did anyone say, you know, gee, if this sting might result in death, maybe we should think of a different way to do it?"
>
> Gregory: "No."
>
> Sauber: ". . .Are there any FBI rules or regulations about when death might result in an investigation, of steps you are supposed to take?"
>
> Gregory: "No" (Ref. 1, p 220)

Would SA Schafer agree that the members of a BAP team ought to assess the potential consequences of their actions? Have such questions ever been raised by any member of his BAP team? Would he consider such questions to be irrelevant? Does grappling with the issue of suicide resulting from a law enforcement sting require that one formally adopt the American Psychological Association (APA) code of ethics? Schafer suggests that "psychologists who do not belong to the APA or another professional association of psychologists are not required to adhere to the

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Reply to Schafer: Exploitation of Criminal Suspects by Mental Health Professionals Is Unethical

Jeffrey S. Janofsky, MD

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Suspected of being a spy, Theresa Squillacote was placed under intense electronic and physical surveillance by the Federal Bureau of Investigation (FBI), as authorized by the Federal Intelligence Surveillance Act (FISA).[1] The psychologist on the FBI's Behavioral Assessment Program (BAP) team used data derived from the surveillance, including phone conversations with her psychiatrist, to assess accurately Ms. Squillacote's specific psychological vulnerabilities. The BAP team then designed an individualized sting operation to take advantage of her weaknesses. In my opinion, the psychologist's behavior violated principles of professional ethics.

In October 1997, Theresa Squillacote and her husband Kurt Stand were arrested for conspiracy to commit espionage. Their arrest was the culmination of an extensive FBI investigation spanning several years. The investigation began after the fall of East Germany, when the United States made a cash payment to an undisclosed source in exchange for records that ostensibly came from the former East German intelligence service and contained the names of the defendants. The government then obtained the first of 20 separate authorizations pursuant to the FISA to conduct clandestine eavesdropping on conversations in the home and hotel rooms of Ms. Squillacote and her husband, as well as on their telephone conversations. Two separate court-approved covert physical searches of Ms. Squillacote's home were conducted as well. After more than 550 days of around-the-clock eavesdropping and surveillance, the FBI uncovered no evidence that the defendants had ever passed classified information.

The government then referred the case to the BAP, which created a report based primarily on information collected from the FBI's surveillance operation. The BAP team consisted of FBI agents and mental health professionals. The identities and credentials of the mental health professionals were never disclosed. The BAP team report led to an undercover sting operation in which an FBI agent played the role of a spy from South Africa. Ms. Squillacote was subsequently charged with and convicted of conspiracy to commit espionage.

The defense raised the issue of entrapment, among other defenses. I testified as a defense expert. I interviewed Theresa Squillacote and Kurt Stand, reviewed Theresa Squillacote's medical and psychiatric treatment records, spoke directly with her treating psychiatrist, and listened to hours of tapes the government had obtained through wiretaps of the defendants' home and telephone calls. Some taped calls were between Squillacote and her psychiatrist, with Ms. Squillacote in an obviously distressed mental state. I also reviewed a copy of the BAP report and the Proposal for Group II UC [Undercover] Operation. The government had redacted several portions of the reports, including the identities and professional titles of the mental health professionals involved. Only at trial did the defense team learn that one of the mental health professionals was a psychologist. The psychologist did not appear at trial, despite defense requests that he or she be made available for cross-examination.

I concluded that the BAP team had accurately as-

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cult. Some states have overcome this hurdle by having violations of their medical or psychology practice acts include violation of professional guidelines. But again, without disclosure of the identity of the BAP psychologist, it is impossible to know whether any state's practice act was violated.

The methodology used by the BAP team is not common in either clinical or forensic psychiatric practice. The BAP team used data obtained in part through wiretapping therapeutic phone conversations between Ms. Squillacote and her psychiatrist, as well as thousands of hours of conversations between Ms. Squillacote and others, recorded in her home and elsewhere. The BAP team then designed an individualized exploitation plan that was executed by an undercover agent. They used material and techniques derived from standard clinical practice, not to provide treatment, but to exploit overtly Ms. Squillacote's psychological vulnerabilities. At the same time, the BAP team indirectly interfered with Ms. Squillacote's ongoing psychiatric treatment by deliberately working against the treatment plan designed by her treating psychiatrist.

Obviously, mental health professionals on the BAP team did not have a direct physician-patient relationship with Ms. Squillacote and did not directly owe her the beneficence and nonmaleficence that are usual in ethical clinical treatment. However, Stone[3] and Diamond[4] have argued against such misuse of clinical techniques in forensic practice. In my opinion, the BAP team's use of clinical information and techniques to exploit Ms. Squillacote's psychological vulnerabilities represent such an irresponsible, unethical practice.

The BAP team did not follow forensic psychiatric principles of ethics either. Appelbaum[2] has written that advancing the interests of justice through truth-telling and respect for persons are the two core principles on which rest forensic psychiatry's rules of ethics. He concludes that such principles exclude the "use of deception in the quest for truth."[5] Halpern[6] points out that there are limits to the forensic psychiatrist's ethical duty to advance the interests of justice and warns psychiatrists to be alert to being drawn into unethical conduct "in the service of an elusive and not infrequently unjust justice." Weinstock[7] and Diamond[4] argue that although truth-telling and respect for persons are important principles of ethics in forensic psychiatry, they are not sufficient and must be balanced with traditional values of medical practice. Weinstock[7] contends that some situations require forensic psychiatrists to perform roles that are so foreign to values of traditional medical practice that the only ethical solution is for the forensic psychiatrist to turn down the case. Diamond[4] argues that the society makes "ceaseless demands for applications of psychiatry and psychology to the law that are frequently inappropriate, impossible and highly undesirable" and that it is up to psychiatry as a profession to resist.

The BAP team's overt use of lying and deception to target a specific person who had not yet committed a crime, for the purpose of maximizing the probability that she would commit a crime, does not further the ethical goals of truth-telling and respect for persons. Such tactics were therefore ethically prohibited by Appelbaum's[2] model of serving the interests of justice and Halpern's,[6] Weinstock's,[7] and Diamond's[4] more mixed models. Finally, by evaluating Ms. Squillacote before she was represented by legal counsel, the BAP team evaluator directly violated the American Academy of Psychiatry and the Law's Ethics Guideline III, which prohibits forensic evaluation of individuals charged with criminal acts before they are allowed access to or are apprised of availability of legal counsel.[8]

The principles of ethics behind the methodology used by BAP mental health professionals should be debated and discussed. Such a debate cannot move forward unless the U.S. Government allows psychiatrists, psychologists, and other mental health professionals who participate in the BAP to be named, to discuss their roles, and to be evaluated by peers.

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Reply to Schafer: Ethics and State Extremism in Defense of Liberty

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For the past 30 years these pages have seen forensic practitioners struggle with the subtleties of forensic ethics, with the balance of clinical and social responsibilities, and with the demands of dual agency. How best does the forensic professional practice in the dual role of clinician and agent of social control? Stated more broadly, how ought one use clinical expertise as an agent of society? We have read of the need to avoid seducing an evaluee into a therapeutic relationship, of the elusive nature of perfect objectivity, of the primacy of truth-telling, of the importance of an individual's historical narrative, of the necessity of preserving civil and criminal rights, and of the nearby influence of clinical ethics.[1–6]

It is heartening to find a case with national security implications that draws on these discussions and calls on a distinguished officer of the Academy to testify on the ethics of forensic practice. It is likewise disheartening to find a polemic in this issue that ignores the subtleties of thought so carefully explicated over the years.[7] Which thread in the decades-old discussion should we follow in a case that involves forensic practice in pursuit of a suspected spy?

Students in introductory philosophy are often asked to engage in a thought experiment that tests their conceptualization of social roles. They are asked to consider a society that permits a citizen firing squad to punish criminals. They imagine citizens from various walks of life doing the punitive work of the state. Then they are asked to imagine a physician's volunteering to join the execution. The physician is within her rights; she is not prohibited from participating. All other things being equal, does this have an effect on the fabric of social roles? Does it affect the community's view of the individual? Of the profession?

The mainstream response is that the physician's participation indeed does violence to social roles and community expectations. The American Medical Association and World Psychiatric Organization, for example, use this reasoning to oppose physicians' participating in executions. The U.S. Supreme Court followed this logic in denying the right to physician-assisted suicide. This is because there are significant social expectations built on the provision of licensure, status, and clientele to a profession founded on trust, beneficence, and care. They are expectations built on a "triple-contract" model, a social contract with reciprocal obligations of practitioners, clients, and community.[8] Stepping out of role may consequently undermine professional integrity and identity. With deception and subversion in the mix, as when a psychologist uses expertise endorsed for one purpose by the social contract to serve another purpose (e.g., espionage), social roles are similarly challenged.

What happens when a clinical professional steps out of a classic social role? This is not a new question. We have asked it in the military context when clinicians must heal soldiers to return them to battle. We have asked it in the correctional context when clinicians must return inmates to the environment causing or exacerbating their illnesses. We are now asked to consider it in the context of protecting the nation's secrets. Is it ethical for a psychologist in a forensic role to use clinical science and a "target's" secretly re-

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of the most influential doctrines in Western thought on just this anti-utilitarian approach.[10] John Rawls, one of this century's most important writers on justice observes, "Each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override." (Ref. 11, p 3). Similarly, in the espionage case we are examining, a greatest-good-for-the-greatest-number approach sacrifices the very moral ideals it values when it trades off individual rights for protection of state secrets.

So, if professional ethics hold some sway, and moral rules stand even when the stakes are high, how are we to balance the rights of society and the individual? After all, as Leslie Danoff points out,[12] we use profilers in criminal investigations and forensic professionals throughout the judicial system. What elements of the Squillacote case best clarify our reasoning?

Mainstream ethics, like the professional ethics of forensic psychologists, concerns itself mightily with matters of social justice, adopting a balancing approach between society and individual when the two conflict. The most common approaches acknowledge control and power differences and adjust formal protections to compensate for imbalance. Forensic ethics reflect this paradigm by including warnings on limitations of confidentiality, instructions on the need for counsel, and censorship of an evaluee's irrelevant personal information. The power differential is acknowledged with individual protections.

Consequently, in cases in which there is less scrutiny, such as espionage investigations, the burden falls more heavily on the state to show care in exercising its power. Because the individual is more vulnerable in this setting, the moral requirement is for greater protection. Certainly, forensic practitioners may turn their expertise to state use if the parameters are defined by open discussion. But if the intervention is shrouded in secrecy, the onus is on the state (and the practitioner) to ensure protection of the individual. This is true for other morally compelling reasons as well.

The need for individual protection increases because the penalties are dire: Criminal sanctions for espionage can be severe indeed. The higher the risks of harm, the greater the protection required. This is not a new idea in the law. Furthermore, the trigger for investigation (e.g., the suspicion threshold of the Foreign Intelligence Surveillance Act [FISA]) is more primitive in its protections of the accused. Add to this a crime that has yet to be committed, and the burden on the state grows even further. I, like Danoff, was impressed that FBI documents admitted a lack of certainty on the extent—and even existence—of espionage.[13]

Against the backdrop of American jurisprudence, the level of individual protection is an important moral point. Our legal system is one of imperfect procedural justice (Ref. 11, p 85). That is, it recognizes that perfect justice may not be attainable in all circumstances. Therefore, complex trial procedures and rules of evidence (namely, due process) are constructed to approximate a just result. Due process is the currency of the legal system—the moral process. In cases in which there is less due process (as in espionage investigations, FISA) the burden is on those who would restrict it.

The equivalence of legal procedure and moral process underscores the importance of narrative in understanding the ethics of this case. Schafer contends that Theresa Squillacote's family and history do not contribute to the moral discussion. We might be generous and allow Danoff, a producer of documentaries, some leeway in establishing a story line. But as moral observers, we especially want to know how the protagonists arrived at their moral crossroads. Are there elements of coercion, illness, and personal vulnerability that weaken justification for the combined intervention of psychology and state power? Are there historical circumstances that mitigate the seriousness of the betrayal? Does the narrative even indicate a betrayal without the psychologist's intervention? Much information is necessary before deciding the moral nature of the act and whether it justifies the psychologist's use of her talents outside the usual clinical and forensic agreements.

The entire field of narrative ethics concerns itself with the process individuals use to reach their moral conclusions. Here, as in law, narrative is a procedure that constitutes moral process.[14] Forensic practitioners use just this narrative approach when exploring the thoughts, feelings, and behaviors that lead someone to commit a crime. Moreover, forensics has recently incorporated narrative ethics into its theory on ethics.[4,9] It could not be more relevant to an understanding of this case.

It appears that professional ethics, the social contract, and the common balance between individual

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Reply to Schafer: Doing Harm

Thomas Grisso, PhD

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I have been asked to comment on the following circumstances. In a recent issue of this journal, Leslie Danoff, a journalist, expressed dismay that a psychologist devised an "undercover blueprint" to assist the FBI in catching an alleged spy, Theresa Squillacote.[1] The plan that the psychologist devised played on Ms. Squillacote's emotional vulnerability, as a consequence of her apparent mental disorder, to lure her into a situation that would result in her capture. Ms. Danoff asked how a psychologist, "a professional trained to heal," could possibly engage in a plan that was "highly likely to result in harm" to Ms. Squillacote (Ref. 1, p 218).

Ms. Danoff did not claim that the psychologist's behavior was unethical. She simply posed questions similar to the one just quoted, and then cited Dr. Jeffrey Janofsky, a forensic psychiatrist who, during expert testimony, had accused the psychologist of unethical behavior. Ms. Danoff's quotations of Dr. Janofsky's testimony did not offer Dr. Janofsky's logic for his assertion. They simply indicated that he called the psychologist's behavior unethical and said he did not think mental health professionals should be doing such things.

Special Agent (SA) John Schafer, a psychologist with the Federal Bureau of Investigation (FBI), offers a contrary view.[2] His sole argument rests on the assertion that the American Psychological Association (APA) ethics code does not apply outside the client-practitioner relationship and that there was no such relationship between the psychologist and Ms. Squillacote. Absent the applicability of that code of ethics, he argues, what is ethical becomes a matter of one's personal choice, especially regarding the value of catching spies as an end that justifies deceptive interest of the nation's welfare.

It should be noted that according to Ms. Danoff, Dr. Janofsky also asserted that the code of ethics for psychologists was of little assistance in this case, because "the APA [American Psychological Association] ethics guidelines contain little of relevance for practicing outside the doctor-patient relationship" (Ref. 1, p 218).

Ms. Danoff did not absolutely assert that the FBI psychologist's behavior was unethical, but she was disturbed by it because of her belief that psychologists are "trained to heal." Are they?

Moreover, the psychologist's behavior, as described, was obviously deceptive and predictably damaging to Ms. Squillacote, both legally and psychologically. Can we ever condone a psychologist's behavior that predictably will be harmful to a person with a mental disorder?

Finally, both Janofsky and Schafer appear to agree that this situation, because it did not involve a client-practitioner (doctor-patient) relationship, could not be examined from the standpoint of the APA's code of ethics for psychologists. Can it not?

All the parties speaking about these issues manifest fundamental misunderstandings about psychology as a profession and about the ethics obligations of psychologists.

Psychology is Not a Mental Health Profession

First, psychology is not a mental health profession, and a large percentage of psychologists are not "trained to heal." Psychology as an organized field began in the 18th or 19th century, depending on whose history one is reading. It was a branch of philosophy that sought to understand human behavior and to use that understanding to improve the human condition. It has achieved the status of a science as a

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nostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness." Ethics concerns covered in the APA code of ethics refer not only to therapeutic relationships, but also to ethics obligations of psychologists in relation to research participants (animal and human), other psychologists, communities, corporations, and governments.

Therefore, that the psychologist who assisted the FBI investigation was not involved in a doctor-patient relationship in no way sets aside the application of the APA code of ethics for purposes of considering the propriety of the psychologist's behavior. It covers all applications of psychology in every aspect of society, which goes far beyond the world of health care.

Psychologists' Obligations Are to Individuals and Society

If Schafer had not rejected the relevance of APA's code of ethics for the case at hand, he would have been able to analyze the case within the framework of the code. The analysis might have gone something like this.

The APA code of ethics recognizes, from its preamble through to the end of its specific ethics standards, that decisions about one's behavior as a professional often require the weighing of competing positive values. Moreover, in the abstract, the APA code of ethics places no heavier value on our obligations to individuals than our obligations to society in general. Almost every time that the welfare of individuals is mentioned in the preamble, it is coupled with attention to the welfare of society. In the more detailed ethics standards portion of the code, most references to patients are followed by a reference to organizations as well (e.g., Standard 5.01, "Psychologists discuss with persons and organizations . . . the relevant limitations on confidentiality").

When one is in a doctor-patient relationship, of course, any analysis of competing positive values involving the individual and society must begin with a presumption that one's obligation to the patient is paramount. Any action that would potentially harm the patient must involve a very compelling interest in the protection or welfare of others in society to override one's obligation to the patient.

When the case does not involve a doctor-patient relationship, then the analysis of competing positive values seeks what is considered to be the more compelling value under the circumstances. Dr. Janofsky apparently understood this when he said that no psychologist or psychiatrist has any business performing this kind of evaluation, even if it serves the interests of the state. In his view, the harm to the individual as a consequence of the psychologist's behavior exceeded the value to public welfare. In Schafer's view, the value to society in supporting a deception against the suspected spy, Ms. Squillacote, was so important that it justified the psychologist's role in an action that was likely to cause her pain and suffering.

In my view, both Janofsky and Schafer were wrong in presuming that the APA code of ethics was irrelevant to this analysis, but neither is necessarily wrong in his conclusions. What is absent is the reasoning that is critical to weighing the force of their judgments. If either of them had not rejected the applicability of the APA code of ethics, they would have found ample material for framing the debate, as the following phrases from the code's General Principles plainly show:

1. Principle B: Integrity (e.g., psychologists ". . . are honest, fair, and respectful of others. . .")
2. Principle C: Professional and Scientific Responsibility (e.g., avoid conduct that may "reduce the public's trust in psychology and psychologists")
3. Principle D: Respect for People's Rights and Dignity (e.g., respect the "fundamental rights, dignity, and worth of all people")
4. Principle E: Concern for Others' Welfare (e.g., when conflicts in principles of ethics arise, "attempt to resolve [them] . . . in a responsible fashion that avoids or minimizes harm")
5. Principle F: Social Responsibility (e.g., "Psychologists are aware of their professional. . . . responsibilities to the community and society")

Moving on to specific Ethics Standards, they could have framed their debate in reference to such Standards as:

1.09, "Respect for Others"
1.14, "Avoiding Harm"
1.16, "Misuse of Psychologists' Influence"
2.02, "Competence and Appropriate Use of Assessments and Interventions"

Merely using the Principles and Ethical Standards in the APA code of ethics would not, of course, have produced a clear winner in this debate. That is Schafer's point. How a professional weighs the competing positive values in cases such as this depends in part on the professional's own values. One professional places more weight on the sanctity of the individual and the damage to the public's perception of "mental

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