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Medical involvement in torture today?

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In the ethics classroom, medical involvement in torture is often discussed in terms of what happens or has happened elsewhere, in some imagined country far away, under a military dictatorship for example, or historically in Nazi Germany or Stalin's Russia. In these contexts, at a distance in space or time, the healthcare professional's moral dilemma can be clearly demonstrated. On the one hand, any involvement whatever in the practice of torture, countenancing or condoning as well as participating, is forbidden, formally by the World Medical Association 1957 Declaration of Tokyo, but more generally by the professional duty to do no harm. On the other hand, the professional duty of care, and more generally human decency and compassion, forbids standing idly by when no other professional with comparable skills is available to relieve the suffering of victims of torture. In such circumstances, the health professional's impulse to exercise their duty of care, albeit thereby implicitly countenancing or condoning torture, may be strengthened by the knowledge that to refuse may put their own life or that of a member of their family in danger. But then again, they may also be all too aware that in exercising their duty of care they may simply be 'patching up' the victims in order for them to be tortured again.

Ethics classroom discussion of medical involvement in torture can be a productive way of exercising moral imagination in seeking possible ways of resolving or ameliorating apparently intractable moral dilemmas. In discussing such moral dilemmas, moral imagination can also be exercised, and may be enlarged, by trying to understand these dilemmas from the point of view of each of the moral agents and moral patients involved. This sympathetic aspect of moral imagination however, is more difficult to exercise in relation to the historical or 'imagined country' scenarios suggested above. Part of the reason for this is that the circumstances seem too distant from the everyday realities of medical practice in developed democratic societies of the twenty-first century: while dual loyalties in contemporary medical practice and research can raise ethical questions, these mainly involve not doing

possible good rather than doing or countenancing or condoning actual harm; and with sufficient clarity and appropriate consent the ethical issues may be safely negotiated. Lessons from the concentration camps and gulags of the twentieth century moreover, discourage attempts to understand things from the point of view of physicians or other health workers who collaborated with the Nazi or Stalinist regimes, or indeed of any who may be tempted today to collaborate with undemocratic regimes which employ torture. The tragic plight of an individual forced to collaborate at the point of a gun may be acknowledged, but only as a rare exception to the rule that health workers should never in any circumstances, as the Tokyo Declaration puts it, 'countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures'.

In developed democratic societies of the twenty-first century however, the ethics of medical involvement in torture may not be as straightforward as this categorical statement suggests. This issue of the *Journal of Medical Ethics* includes four significant contributions to a current Australian debate on the subject; and these suggest that its moral complexity has not gone away and may become a matter of moral concern elsewhere. The immediate context of this debate is that of the remote offshore detention centres in which 'boat people' from Asian countries seeking asylum in Australia are detained, ostensibly to check that they are not a risk to national security if asylum is granted to them. Such security checks will no doubt seem reasonable not only to many Australians but also to many in Europe and other desired destinations of refugees from war-torn or impoverished parts of the world: the possibility that some have potentially harmful intentions cannot be excluded. And since, in Europe recently, Australia's immigration control policies are frequently cited as an example for others to follow, the practices of its detention centres and the role of health professionals in those centres should be of interest and moral concern elsewhere also.

Just why these practices should be of moral concern is clearly set out in a

report by Professor David Isaacs (*see page 413*), who writes from personal experience of providing paediatric services in one such immigration detention centre. The average period of detention, he observes, has now 'increased from 10 weeks to 14 months', during which 'detainees are not informed of the progress of their application for refugee status'. While security checking is the officially stated reason, the underlying intention of such prolonged detention, Isaacs suggests, 'is arguably to coerce asylum seekers into voluntarily returning to their own or another country and to deter others from seeking asylum'. 'Prolonged detention without trial' however 'is illegal in Australia as in most other democratic countries' and is possible in the detention centres only because they have been artificially isolated from Australia by legal 'sleight of hand'.

Well-recognised consequences of prolonged immigration detention, Isaacs reports, are 'severe mental health problems including anxiety, depression, post-traumatic stress disorder, self-harm and suicidality'. Indeed, such detention, often accompanied by 'constant bullying and humiliation' of detainees, might well be classified as torture according to United Nations criteria. And if that is the case, health care professionals meeting the 'pressing mental and physical health needs' of detainees could well be colluding with unethical practices. To escape this charge, Isaacs concludes, each of these professionals needs to decide 'for how long and to what extent restrictive contracts and gagging laws' to which they are subject by their terms of employment 'will constrain them from advocating for closing detention centres'.

Isaacs' account is endorsed and expanded in commentaries by Howard Goldenberg (*see page 416*), Ryan Essex (*see page 418*), and Deborah Zion (*see page 420*). Dr Goldenberg, a general practitioner who also has worked in offshore detention centres, vividly illustrates the deeply harmful consequences not only for detainees, but also for doctors who have to care for them in what he characterises as an essentially 'unkind system', which delimits the doctors' 'own capacity to do

good and puts them at 'moral hazard' of 'violence against our own values'. Like Isaacs, Goldenberg does not 'categorically declare' the treatment of detainees to be torture, but his comparison of its effects on the human spirit with that of dehumanising treatment in the Nazi concentration camps is if anything even more damning. Despite this, and unlike others who (as Essex notes) have earlier called for a medical boycott of these detention centres, Goldenberg argues that working in such centres can be ethically justified by doctors, but only insofar as their terms of employment imply a refusal to do harm: if a doctor comes to believe that they are in practice being required to do harm, then they should make public their refusal, even at the risk of imprisonment with which recent Australian law threatens any professional whistle-blower.

What seems to these authors almost as morally offensive as torture is the secrecy which surrounds the detention centres: Isaacs and Goldenberg both emphasise the

moral imperative on health professionals who have worked there not to remain silent about what they have seen: 'the risk of incarceration', in Goldenberg's telling phrase, is 'a hazard, yes, but in our relatively non-totalitarian system a hazard without risk of death... A hazard certainly, but not a moral hazard'. In her commentary Dr Zion agrees, arguing that what the detention centres have in common with all regimes that commit human rights abuses is secrecy. In order to dispel this it is not enough for individuals to speak out. In order to increase transparency and act 'as a deterrent to human rights violations in the first instance', she argues, the Australian Government must endorse its medical community's call no longer to leave unratified the United Nations Protocol allowing 'for monitoring of places of detention by domestic and international bodies'.

Whether this call will be heeded by the Australian Government remains to be seen. Popular sentiment in relatively peaceful and prosperous countries which

are the desired destination of migrants from war-torn or impoverished parts of the world may not always wish to know all of the means by which immigration is controlled. Internationally however, the medical community cannot now easily go back on its commitment to not countenancing, condoning or participating in 'the practice of torture or other forms of cruel, inhuman or degrading procedures'; and this commitment is likely to be strengthened whenever individual health care professionals such as Professor Isaacs and Dr Goldenberg refuse to remain silent about circumstances in which encountering such procedures has led them or others into acute moral dilemmas or even moral hazard. Politics, as always, will prove 'a slow boring of hard planks': but as a wise English academic is said to have recently remarked, perhaps the one evidence of moral progress in contemporary society is that 'today it has become increasingly difficult to bury bad news'.

Europe: don't adopt Australian style immigration system, warn ethicists

Its lack of transparency is helping perpetuate human rights abuses and torture in detention centres

European countries should not adopt Australia's immigration system, with its emphasis on deterrence, warn ethicists in a special issue of the ***Journal of Medical Ethics***, dedicated to global medical ethics.

The system's lack of transparency is helping perpetuate ongoing human rights abuses and what amounts to the torture of asylum seekers in remote offshore detention centres, they argue.

Furthermore, the introduction of the Border Force Act, which entered the statute book in July 2015, makes speaking up about abuse by current or former 'trusted persons' including health professionals, a criminal offence, punishable by a two year prison sentence.

"The situation in Australia is particularly important when seen in the broader context of the humanitarian crisis in Syria, which is forcing people to seek refuge throughout the Middle East and Europe," write Dr John-Paul Saggaran of the University of New South Wales in Sydney, and Professor Deborah Zion of the Centre for Cultural Diversity and Wellbeing, Victoria.

And never more so now that European countries, including the UK, have expressed interest in adopting Australian styled and inspired immigration policies, they say.

Despite the legal gags, allegations of waterboarding—a technique that simulates drowning—'zipping', whereby an individual is tied down to a metal bed frame which is then thrown in the air, force feeding during hunger strikes, restraints used for deportation, and the incarceration of children, have nevertheless surfaced, say the authors.

And the United Nations special rapporteur on torture has found Australia to be in breach of the UN Convention Against Torture, despite having signed up in 2009 to the Optional Protocol on the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, or OPCAT, for short.

"The lack of access to respectable standards of medical care has been recognised by peak Australian health bodies and belatedly by the Australian Medical Association as constituting 'state sanction of child abuse and elsewhere as torture,'" they point out.

They add that regimes that commit human rights abuses are marked by secrecy and a lack of accountability.

"It is, therefore, of great concern and significance that the frameworks which enshrine human rights and protect asylum seekers have long been absent in the Australian detention system"—in stark contrast to all other healthcare environments which maintain high levels of reporting, record keeping, and vigilance, they write.

A preparedness to ratify OPCAT would enable jailers and doctors in Australia to speak openly about what they have witnessed, say the authors, who praise the health sector for taking such a strong stance in pressing for the ratification of the treaty.

But Australia's approach should be a lesson to all countries grappling with migration, they warn.

"Europe is contending with the largest migration since the Second World War resulting from the Syrian crisis. The authors in the strongest possible terms counsel others against following on the same path as Australia, lest the same mistakes and unjustifiable suffering come to be repeated," they say.

In a linked editorial, the journal's associate editor, Professor Kenneth Boyd, says that detaining people to check whether they represent a risk to national security may not seem unreasonable to

Australians and the citizens of European countries. Some migrants may indeed have harmful intentions, he says.

But “as Australia’s immigration control policies are frequently cited as an example for others to follow, the practices of its detention centres and the role of health professionals in those centres should be of interest and moral concern elsewhere also,” he suggests.

But he adds: “Popular sentiment in relatively peaceful and prosperous countries which are the desired destination of migrants from war-torn or impoverished parts of the world may not always wish to know all of the means by which immigration is controlled.”