Appendix 1
Regulations in Time of Armed Conflict[1]

World Medical Association

1. Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the *International Code of Medical Ethics* of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.
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.
   (d) Employ personal health information to facilitate interrogation.
   (e) Condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.

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.

[1] Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, and 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, and editorially revised at the 173rd Council Session, Divonne-les-Bains, France, May 2006.

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.
12. Physicians must be granted access to patients, medical facilities and equipment and the protection needed to carry out their professional activities freely. Necessary assistance, including unimpeded passage and complete professional independence, must be granted.
13. In fulfilling their duties, physicians and other health care professionals shall usually be identified by internationally recognized symbols such as the Red Cross and Red Crescent.
14. Hospitals and health care facilities situated in war regions must be respected by combatants and media personnel. Health care given to the sick and wounded, civilians or combatants, cannot be used for morbid publicity or propaganda. The privacy of the sick, wounded and dead must always be respected.

Appendix 2
Statement on Torture, Cruel, Inhuman or Degrading Treatment[1]

World Medical Association

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…*"

[1] Full title: "The World Medical Association Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of Which They Are Aware."

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

Recognizing

14. That careful and consistent denunciation by physicians of cases of torture and of those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity
15. That physicians, by ascertaining the sequelae and treating the victims of torture, either early or late after the event, are privileged witnesses of this violation of human rights
16. That the victims, because of the psychological sequelae from which they suffer or the pressures brought on them, are often unable to formulate by themselves complaints against those responsible for the ill-treatment they have undergone
17. That the non-denunciation of acts of torture may be considered as a form of tolerance thereof and of non-assistance to the victims
18. That nevertheless there is no consistent and explicit reference in the professional codes of medical ethics and legislative texts of the obligation upon physicians to report or denounce acts of torture or inhuman or degrading treatment of which they are aware

Recommends that National Medical Associations

19. Support the adoption in their country of ethical rules and legislative provisions:
    19.1 Aimed at affirming the ethical obligation on physicians to report or denounce acts of torture or cruel, inhuman or degrading treatment of

which they are aware; depending on the circumstances, the report or denunciation would be addressed to medical, legal, national or international authorities, to non-governmental organizations or to the International Criminal Court. Doctors should use their discretion in this matter, bearing in mind paragraph 68 of the Istanbul Protocol.[2]

19.2 Establishing, to that effect, an ethical and legislative exception to professional confidentiality that allows the physician to report abuses, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent.

19.3 Cautioning physicians to avoid putting individuals in danger by reporting on a named basis a victim who is deprived of freedom, subjected to constraint or threat or in a compromised psychological situation.

20. Disseminate to physicians the Istanbul Protocol
21. Promote their training on the identification of different modes of torture and their sequelae
22. Place at their disposal all useful information on reporting procedures, particularly to the national authorities, nongovernmental organisations and the International Criminal Court

[2] Istanbul Protocol, paragraph 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 has 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 breaking 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."

Appendix 3
Physician Participation in Interrogation (Res. 1, I-05) [1,2,3,4]

Council on Ethical and Judicial Affairs, American Medical Association

1 Introduction

At the 2005 Interim Meeting, the House of Delegates adopted amended Resolution 1, I-05, "Physician Participation in the Interrogation of Prisoners and Detainees," which directed the Council on Ethical and Judicial Affairs to delineate the boundaries

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[1] This report has been reformatted to accord with this volume. Use with permission. Copyright American Medical Association, 2006.

[2] The Council gratefully acknowledges the following individuals and organizations for reviewing an earlier draft of this Report. (This acknowledgement does not represent endorsement of the final report nor its recommendations): American Academy of Child and Adolescent Psychiatry (David Fassler, M.D.); American Academy of Pediatrics (Eileen M. Ouellette, M.D., JD, FAAP, Tomas J. Silber, M.D., MASS, Chairperson, Executive Committee on Bioethics); American Academy of Psychiatry & the Law (Howard Zonana, M.D., Robert Phillips, M.D., Ph.D.); American Psychiatric Association (Steven Sharfstein, M.D., Paul Appelbaum, M.D.); Office of the Army Surgeon General (Col Elspeth Ritchey, M.D.); Physicians for Human Rights (Leonard S. Rubenstein, JD); Uniformed Services University (Edmund Howe, Ph.D.; Thomas A. Grieger, M.D.); United States Air Force Medical Service (Brig Gen David Young, M.D.; Col Arnyce Pock, M.D.; Lt Col Paul Friedrichs, M.D.; Maj Val Finnell, M.D., Joe Procaccino, JD); Vice Admiral Donald C. Arthur, M.D., US Navy Surgeon General; Lieutenant General Kevin C. Kiley, M.D., FACOG, US Army Surgeon General; Lieutenant General George "Peach" Taylor, M.D., US Air Force Surgeon General; Scott A. Allen, M.D., Clinical Assistant Professor of Medicine, Brown Medical School; George J. Annas, JD, MPH, Edward R. Utley Professor, Boston University School of Public Health; M. Gregg Bloche, M.D., JD, Professor of Law, Georgetown University; Burton J. Lee, M.D.; Steven Miles, M.D.; William Winkewerder, Jr., M.D., Assistant Secretary of Defense, Health Affairs; Stephen N. Xenakis, M.D., Brigadier General (Retired) US Army.

[3] Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

[4] Note: The Council on Ethical and Judicial Affairs presents CEJA Report 10, A-06, "Physician Participation in Interrogation," as a Late Report, acknowledging that this limits the time during which Delegates can review the full report. However, the Council sought input from a large number of interested organizations and individuals by sharing an early draft of the Report. Because this topic has been the focus of considerable ongoing public debate, the Council believes it is in the best interest of the AMA and particularly of colleagues currently serving in the military to present the Report to the House at this time, as a Late Report.

of ethical practice with respect to physicians' participation in the interrogation of prisoners and detainees.

The resolution arose from concerns in recent years regarding the role of physicians in interrogation practices, including involvement as Behavioral Science Consultants to advise interrogators.[5] This report focuses on the role of physicians in the interrogation process in the specific contexts of domestic law enforcement and military or national security intelligence gathering.

2 Elements of the Debate

2.1 Interrogation: Definition and Description

For the purpose of this Report, we define a "detainee" as a criminal suspect, prisoner of war, or any other individual who is detained and is potentially subject to interrogation. An individual who undergoes interrogation is referred to as an "interrogatee." Most broadly, interrogation has been defined as formal and systematic questioning.[6] However, in this Report, we define interrogation more narrowly, as questioning related to law enforcement or to military and national security intelligence gathering designed to prevent the occurrence or recurrence of harm or danger to individuals, the public, or national security. The interrogation aims to elicit information from a detainee that is useful to the purposes of the interrogators. Interrogations are also distinct from questioning used to assess the medical condition of an individual or to determine mental status. Accordingly, forensic medicine practices that include assessing competence to stand trial or criminal responsibility, and pre-sentencing evaluations are excluded from this report. Appropriate interrogations should be carefully distinguished from those coupled with coercive acts that are intended to intimidate and that may cause harm through physical injury or mental suffering. In general, this Report does not address participation of physicians in developing strategies to deal with individuals who are not in detention, such as negotiations

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The Council considers that the time required to process the wide range of comments that were solicited, which resulted in the delay in submitting this Report to the House, was time well spent. After thorough reflection and deliberation on the broad spectrum of sharply conflicting opinions of reviewers, the Report now strongly and clearly describes the ethics of physicians as they relate to interrogations. The Council members are deeply grateful to all those who participated in this process.

[5] Michael Wilks, "A Stain on Medical Ethics," *Lancet* 366 (2005): 429–431; Peter Slevin and Joe Stephens, "Detainees' medical files shared," *Washington Post* (20 June 2004): A1; Robert Jay Lifton, "Doctors and Torture," *New England Journal of Medicine* 351 (2004): 415–416; M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *New England Journal of Medicine* 352 (2005): 3–6; Neil A. Lewis, "Interrogators Cite Doctors' Aid at Guantanamo," *New York Times* (24 June 2004): A1.

[6] Bryan A. Garner, ed., *Black's Law Dictionary*, 8th ed. (St. Paul, MN: Thomson West, 2004).

with hostage takers and profiling of criminal suspects. From the physician's perspective, an interrogation is distinct from questioning conducted for purposes of making a diagnosis, assessing physical capacity, or determining mental capacity related to legal status.

The military and related government agencies refer to interrogations, debriefings and tactical questioning as means to gain intelligence from captured or detained personnel.[7] The Army Field Manual further defines interrogation as "the process of questioning a source to obtain the maximum amount of usable information. The goal is to obtain reliable information in a lawful manner, in a minimum amount of time, and to satisfy intelligence requirements of any echelon of command."[8]

2.2 Interrogation Techniques

The Army Field Manual provides detailed guidance on interrogations and describes methods to establish rapport with or exert control over a detainee. Specific psychological strategies that rely primarily on incentives, emotions, fear, pride and ego are generally considered acceptable, although it is recognized that approaches that rely on fear presents "the greatest potential to violate the law of war."[9]

Significant concerns regarding interrogations arise from the risk of abuse. Domestic and international law prohibit the use of coercive interrogations that might involve the application of mild to severe physical or mental force.[10]

In criminal law, coercion or undue intimidation violates the rights of individuals being interrogated. Moreover, such abuses can undermine the veracity of information derived from an interrogation and can jeopardize subsequent legal proceedings intended to establish true facts about a crime.[11] Therefore, safeguards of due process have been placed on interrogatory powers in order to protect against coercive techniques.[12] Actions by law enforcement agents may be legally reviewed, and information gathered by coercive means may be rejected from court proceedings.

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[7] United States Department of Defense, *Intelligence Interrogations, Detainee Debriefings and Tactical Questioning*, DOD Directive 3115.09 (3 November 2005).

[8] United States Department of Defense, *Army Field Manual 34–52* (Washington, DC: 1992), P. 1–6.

[9] Ibid.

[10] Robert Galvin, "The Complex World of Military Medicine: A Conversation with William Winkenwerder," *Health Affairs* 2005: W5-353–360; Alan Elsner, "Experts See Medical Ethics Violations at Guantanamo," *Reuters* (24 February 2006).

[11] American courts recognize that confessions elicited by physical intimidation are involuntary and may not be admitted against the confessor at trial. Additionally, under certain circumstances threats, deception, and trickery may render a confession involuntary and inadmissible. 29 Am. Jur. 2d Evidence §731.

[12] The Fifth and Fourteenth Amendments to the Constitution protect individuals against involuntary self-incriminating statements. *Dickerson v. United States*, 530 US 428 (2000); *Miranda v. Arizona*, 384 US 436 (1966).

Policies that traditionally have governed military or national security interrogations expressly prohibit "acts of violence or intimidation, including physical or mental torture, threats, insults, or exposure to inhumane treatment as a means of or aid to interrogations."[13] Thus, there are limits to manipulating or exploiting an individual's physical and mental status to elicit information. These limits are grounded in the Geneva Conventions, which in part state: "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 unpleasant or disadvantageous treatment of any kind."[14]

Similar limitations are found in the United Nations' Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which prohibits "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 […]."[15] Accordingly, determining the point at which any interrogation becomes coercive is of great significance. While physicians can provide insights into the physically and mentally harmful effects of interrogation practices, they alone cannot authoritatively define the tipping point between appropriate and inappropriate interrogation practices.

3 Physicians and the Interrogation Process

Some physicians, most often psychiatrists, may engage in activities that are closely linked to interrogations. For example, in the course of criminal proceedings, physicians may be asked to assess the mental condition of an individual who is to be interrogated, either to prevent an interrogation that would be harmful to the individual's health[16] or to identify mental impairments that could negate the value of disclosed information. Other assessments may include the determination of an individual's mental competency to stand trial, or the availability of the insanity defense. Physicians sometimes provide consultations to law enforcement officers regarding fruitful approaches to interacting with suspects, for example, in criminal profiling and hostage negotiations. Specific guidelines for ethical behavior of psychiatrists serving as forensic consultants have been developed by the American Academy of Psychiatry and the Law.[17] In most

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[13] United States Department of Defense, Army Field Manual 34–52 (Washington, DC: 1992), P. 1–6.

[14] Geneva Convention III, Art. 17

[15] UN Convention Against Torture, Pt. I, Art. 1, §1.

[16] Paul M. Jones, Paul M. Appelbaum, and David M. Siegel, "Law Enforcement Interviews of Hospital Patients: A Conundrum for Clinicians," Journal of the American Medical Association 295 (2006): 822–825.

[17] American Academy of Psychiatry and the Law, "American Academy of Psychiatry & the Law Ethical Guidelines for the Practice of Forensic Psychiatry," http://www.aapl.org/ethics.htm, cited 1 June 2006.

of these examples, a physician's training and skills help determine whether a mental impairment exists that would have some bearing on legal proceedings.[18] The physician's primary aim is not to persuade the individual to reveal incriminating information, although such information may be revealed as a secondary consequence of questioning. Similarly, the determination of physical or mental impairments may bear on administrative proceedings, such as eligibility to receive funds or services, but these assessments are also distinct from interrogations as defined in this report.

3.1 General Arguments for and Against Physician Involvement in the Interrogation Process

Without being coercive, interrogations rely on psychological manipulation producing stress, anxiety, or other forms of discomfort. The physical or mental impact of these practices may justify a role for physicians in interrogations.[19] Physicians could enhance the likelihood of successful interrogation by identifying useful strategies, providing information that may be useful during questioning, or putting interrogatees at ease. Furthermore, physicians could protect interrogatees if, by monitoring, they prevent coercive interrogations. However, physician involvement could also lead to the belief on the part of interrogators that they can escalate the use of force until the physician intervenes.[20]

From the perspective of ethical responsibilities, all physicians who engage in activities that rely on their medical knowledge and skills must uphold the principles of beneficence and non-maleficence and refrain from participating in situations that may cause harm without corresponding benefit. They must also respect patient autonomy and must protect the confidentiality of personal information, unless breaching them is clearly justified by tenets of medical ethics. Some benefits of interrogation may accrue to the detainee or to other individuals (e.g., exoneration from a crime), but the intention of interrogation is not to benefit the detainee; rather, it is to protect the public or other individuals from harm due to domestic or foreign threats. These are laudable goals, but it is not clear that the medical knowledge and skills of physicians should be used for purposes unrelated to medicine or health to further the interests of groups against those of individuals, such as detainees. Striking a balance between obligations to individuals and obligations to society

[18] 72 A.L.R. 5th 529.

[19] Susan Okie, "Glimpses of Guantanamo—Medical Ethics and the War on Terror," New England Journal of Medicine 353 (2005): 2529–2534.

[20] M. Gregg Bloche and Jonathan H. Marks, "Doctors and Interrogators at Guantanamo Bay," New England Journal of Medicine 353 (2005): 6–8; Also, see Stanley Milgram, "Behavioral Study of Obedience," Journal of Abnormal and Social Psychology 67 (1963): 371–378. Milgram's study suggests that subjects are more likely to inflict greater harm if under the supervision of an authoritative supervisor.

may be difficult, but when the obligations seem approximately equal, the weight should shift toward individuals.

The principles of respect for autonomy, beneficence, non-maleficence and protection of confidentiality are at risk of being violated during interrogations. Therefore, it is essential that the ethical role of physicians in interrogations be clearly defined.

3.1.1 Physicians' Dual Loyalties

In the clinical setting, physicians' obligations are first to their patients. However, in many other settings, physicians confront dual loyalties, which place the medical interests of the individuals with whom they interact in tension or conflict with those of third parties to whom the physicians are accountable. For example, when a physician assesses an employee's health for an employer, the physician has certain ethical responsibilities to the examinee as well as contractual responsibilities to the employer. However, the AMA's *Code of Medical Ethics* makes clear that the physician must not fulfill responsibilities to the employer in a manner that is detrimental to the employee's medical condition,[21] nor disclose medical information without the consent of the employee.[22]

Physicians who provide medical care in detention or correctional facilities face divided loyalties: to the medical interests of the detainees and respect for their (legally limited) autonomy, and to the correctional facility's control over detainees and need for information. Concerns are heightened when interrogations are conducted.[23] Some, including military and government officials,[24] have suggested that physicians who do not provide medical care to interrogatees are not bound by physicians' ethical obligations to patients because they act outside of the patient-physician relationship. However, various Opinions in the AMA's *Code of Medical Ethics* suggest that physician interactions under the authority of third parties are governed by the same ethical principles as interactions involving patients.[25] Physicians must apply medical knowledge and skills within the profession's ethical standards, which are distinct from and often more stringent than those of the law.

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[21] Council on Ethical and Judicial Affairs of the American Medical Association, "Opinion E-10.03, Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations," Code of Medical Ethics (Chicago: AMA, 2004).

[22] Council on Ethical and Judicial Affairs of the American Medical Association, "Opinion E-5.09, Confidentiality: Industry-Employed Physicians and Independent Medical Examiners," Code of Medical Ethics (Chicago: AMA, 2004).

[23] M. Gregg Bloche, "Caretakers and Collaborators," Cambridge Quarterly of Healthcare Ethics 10 (2001): 275–284.

[24] United States Department of Defense, Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States, HA Policy 05–006 (3 June 2005); United States Department of Defense, Medical Program Support for Detainee Operations, Instruction 2310.08E (6 June 2006).

[25] Council on Ethical and Judicial Affairs of the American Medical Association, "Opinion E-2.06, Capital Punishment" and "Opinion E-2.065, Court-Initiated Medical Treatments in Criminal Cases," Code of Medical Ethics (Chicago: AMA, 2004).

3.1.2 Confidentiality of Detainee Information

Confidentiality is of particular concern when physicians provide medical care in settings where interrogations might occur. Interrogators might believe that interrogation will be more effective if informed by medical information, and might pressure physicians to share information obtained in the course of a patient-physician encounter. Opinion E-5.05, "Confidentiality," places great emphasis on the confidentiality of personal information that patients provide to physicians. The Opinion recognizes limited circumstances in which breaching confidentiality may be justifiable, for example, disclosures related to foreseeable and preventable harm to identifiable third parties. It is otherwise unethical to divulge personal information without the authorization of the patient. When medical records belong to the detention facility, physicians should warn detainee-patients that the information they provide for the medical record is accessible to facility authorities.

Moreover, in the context of physician employment by third parties, information should not be communicated to the third party without prior notification of the interrogatee that any information they provide may be passed on to a third party.[26] The fact that interrogation may be legally mandated or protected does not ethically justify communication of confidential information by a physician without notification and the individual's approval.

3.2 Specific Roles

To assess the ethics of physician involvement in interrogations, it is useful to distinguish various activities in which physicians may be involved.

Physicians are ethically justified in acting to prevent harm to individuals. In this regard, the suggestion that physicians should observe or monitor interrogations to prevent harm requires careful scrutiny. As defined in this report, appropriate interrogations present no reason for medical monitoring, because interrogators ought to abstain from coercive questioning. Physicians can determine that harm has been inflicted but, in many instances, cannot predict whether an interrogation practice will or will not cause harm.

Physicians may be asked to determine the overall medical fitness of detainees or their mental capacity, and to use their knowledge and skills to assess the health of detainees; questioning to elicit medical information of this kind is distinct from interrogations and is appropriate. The presence of a physician at an interrogation, particularly an appropriately trained psychiatrist, may actually benefit the interrogatee because of the belief held by many psychiatrists that kind

[26] Council on Ethical and Judicial Affairs of the American Medical Association, "Opinion E-5.09, Confidentiality: Industry-Employed Physicians and Independent Medical Examiners," Code of Medical Ethics (Chicago: AMA, 2004).

and compassionate treatment of detainees can establish trust that may result in eliciting more useful information. However, physicians who provide medical care to detainees should not be involved in decisions whether or not to interrogate because such decisions are unrelated to medicine or the health interests of an individual.

A physician may be requested or required to treat a detainee to restore capacity to undergo interrogation. If there is no reason to believe that the interrogation was coercive, there is no ethical problem. As with all patients, physicians should not treat detainees without their consent (see Opinion E-8.08, "Informed Consent"). Moreover, in obtaining consent for treatment, implications of restoring health, including disclosure that the patient may be interrogated or an interrogation may be resumed, must be disclosed. If a physician identifies physical or psychological injuries that are likely to have occurred during an interrogation, the physician must report such suspected or known abusive practices to appropriate authorities.

Development of interrogation strategies constitutes indirect involvement in interrogation. Specific guidance by a physician regarding a particular detainee based on medical information that he or she originally obtained for medical purposes constitutes an unacceptable breach of confidentiality. Moreover, it is unethical for a physician to provide assistance in a coercive activity, because such activities fundamentally undermine the respect for individual rights that is basic to medical ethics. The question of whether it is ethically appropriate for physicians to participate in the development of interrogation strategies may be addressed by balancing obligations to society against those to individuals, as noted in the above section on "General Arguments". Direct participation in an individual interrogation is not justified, because physicians in the role of interrogators undermines their role as healers and thereby erodes trust in both themselves as caregivers and in the medical profession, and non-medical personnel can be trained to be expert interrogators. But a physician may help to develop general guidelines or strategies, as long as they are not coercive and are neither intended nor likely to cause harm, and as long as the physician's role is strictly that of consultant, not as caregiver.

Any physician involved with individuals who will undergo or have undergone interrogations should have current knowledge of known harms of interrogation techniques. For example, some research has shown that isolation is a harmful interrogation tactic.[27] Once an interrogation strategy is shown to produce significant harm, whether immediate or long term, it should be reported to appropriate authorities so that its use can be prohibited. If responsible authorities do not prohibit a clearly harmful interrogation strategy, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

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[27] Craig Haney, "Mental Health Issue in Long-Term Solitary and 'Supermax' Confinement," Crime and Delinquency 49 (2003): 124–156; Stuart Grassian, "Psychopathological Effects of Solitary Confinement," American Journal of Psychiatry 140 (1983): 1450–1454.

4 Conclusion

The practice of medicine is based on trust. Physicians are expected to care for patients without regard to medically irrelevant personal characteristics. This fundamental tenet of medical ethics underlies the doctrine of medical neutrality, whereby in times of war physicians are expected to treat casualties within triage protocols, irrespective of patients' military or civilian status.

Any physician involvement with detainees who may undergo interrogation must be guided by the same ethical precepts that govern the provision of medical care, never using medical skills and knowledge to intentionally or knowingly harm a patient without corresponding benefit, and respecting patient autonomy by obtaining consent to the provision of care and protecting confidential information. Physicians have long dealt with problems of dual loyalties in forensic roles and as employees of government and business. The same ethical considerations that guide physicians under those circumstances also guide them in matters related to interrogation. Physicians in all circumstances must never be involved in activities that are physically or mentally coercive. If physicians engage in such activities, the whole profession is tainted.

Questions about the ethical propriety of physicians participating in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to society with obligations to individuals. Direct participation in interrogation of an individual detainee is not justified, because non-medical personnel can be trained to be expert interrogators, minimizing the need for presence of a physician. But, out of an obligation to aid in protecting third parties and the public, a physician may help to develop general guidelines or strategies for interrogations, as long as the strategies are not coercive, and as long as the physician's role is strictly that of consultant, not as caregiver.

5 Recommendations

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

For this report, we define interrogation as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations are distinct from questioning used by physicians to assess the physical or mental condition of an individual. To be appropriate, interrogations must avoid the use of coercion—that is, threatening or causing harm through physical injury or mental suffering. We define a "detainee" as a criminal suspect, prisoner of war, or any other individual who is being held involuntarily by legitimate authorities.

Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold ethical principles. Questions about the propriety of physician participation in interrogations and in the development of interrogation

strategies may be addressed by balancing obligations to individuals with obligations to protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest. Applying this general approach, physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

1. Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.
2. Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.
3. Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.
4. Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.
5. When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations (New HOD/CEJA Policy).

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