

of transinstitutionalisation (eg, transfer of hundreds of patients from a public mental hospital that “must” be closed to hidden private institutions) and provide active support to families of patients who have been deinstitutionalised, so that they are not left alone with their problem.^{7,8}

A fourth fundamental right of a person with a mental disorder is not to be deprived of a full affective and social life because of his or her mental health problem. In the current global financial crisis, people with mental disorders are among the most vulnerable, and programmes for their social inclusion are not always regarded as a priority by local administrators. This neglect must be a target for advocacy by mental health professionals worldwide.

Additional rights of people with mental disorders—emphasised in the WPA survey² and WPA documents^{9,10}—are to be active participants in service planning and delivery, rather than passive recipients of care, and to have access to physical health care of the same quality as that available to the rest of the population, with appropriate insurance coverage.

The WPA is committed to promote the fulfilment of the above-mentioned rights of people with mental disorders, fighting against prejudice, ignorance, misinformation, and ideological fanaticism.

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Ending medical complicity in state-sponsored torture



Since Sept 11, 2001, state-sponsored torture has become increasingly accepted and institutionalised, despite its clear illegality;¹ it is now practised in over 100 countries,² including 14 of the G20 nations.³ Physicians' involvement in torture is especially worrisome, with Abu Ghraib and Guantánamo Bay serving as well-publicised contemporary examples.^{4–6} In the so-called War on Terror, medical complicity has legitimised torture and condoned, justified, and facilitated extreme torture techniques. Doctors have become irreplaceable in modern torture methods; procedures such as cramped confinement, dietary manipulation, sleep deprivation, and waterboarding have at times been legally sanctioned due to medical supervision.⁷

In view of the clear international consensus prohibiting torture, additional laws, protocols, or declarations are unlikely to end medical complicity in torture. Indeed, doctors working for the military, intelligence

agencies, and other governmental entities often face divided loyalty between their employers' orders and medical ethics.⁸ These doctors are immunised from accountability by the same governments that employ them. Instead, to end medical complicity in torture, efforts must be taken to bring existing laws, protocols, and declarations into effect through enhanced adherence, compliance, and accountability.

Yet few politically feasible mechanisms exist to hold individual physicians responsible for torture activities. Globally, almost every international law imposes its obligations on national governments rather than individuals. Corresponding mechanisms for monitoring, investigation, and promotion of compliance are similarly targeted; even if they did contain individual-level mechanisms, cooperation from states would be necessary for enforcement. Many non-binding declarations, codes, and consensus statements that

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condemn medical complicity in torture also focus on states. Those legal devices that do target individuals do not have effective compliance-promoting mechanisms or sanctions (table).

Targeting states is often a necessary strategy depending on the interested organisation and the need for bureaucratic capacity to implement legal obligations. But this system is not working to prevent torture. Understandably, states avoid prosecution of their own doctors who they commanded to monitor, supervise, and even design torture procedures. Universal jurisdiction to prosecute torture has only been partly helpful in view of courts' hesitance and governments' reluctance to indict foreign officials for foreign crimes.⁹ Even US President Barack Obama's administration has not prosecuted any Central Intelligence Agency operatives for past torture-related activities, whether commanded to engage in such behaviour or not.¹⁰ Thus, although medical complicity in torture is banned in nearly every state, domestic criminal prosecution against perpetrators is unlikely.

Without effective state-based legal strategies, various alternative proposals have been put forward to

end medical complicity in torture. One suggestion, for example, is to expand coverage of medical ethics and human rights law in undergraduate, postgraduate, and continuing medical education, complemented by further training of military officials on the appropriate use of physicians in their work.¹¹ Others have proposed a strengthened investigative role for the UN Special Rapporteur on Torture,¹² a new International Tribunal for Investigation of Torture,¹³ and enhanced political advocacy by civil-society organisations.^{3,9} Empowerment of physicians to end torture by refusing to cooperate and documenting cases they encounter has also been suggested.²

One idea that has been explored in less detail is the use of litigation against individual physicians who are complicit in illegal torture activity and then publicising outcomes. Indeed, an extensive multilingual search by Miles and colleagues¹⁴ identified only 56 physicians worldwide who had been punished for complicity in torture or crimes against humanity from 1945 to 2009. Although state-based criminal prosecution is often difficult, perhaps a greater role exists for the International Criminal Court and its Chief Prosecutor to investigate complaints of medical complicity in torture when states are unwilling to do so themselves. Tort-based civil litigation represents another opportunity. Although fraught with difficulties and controversy, the US *Torture Victim Protection Act* and *Alien Tort Statute* (28 U.S.C. § 1350),¹⁵ for example, allow individuals or organisations to file claims against torturers even if the impugned act occurred abroad or was undertaken by non-Americans. Domestic medical regulators could similarly launch disciplinary proceedings, identify ethical transgressions, and punish offenders, although so far they have shown considerable reluctance.¹⁶

No matter the approach pursued, litigation successes must be coupled with publicity, lest we perpetuate undeserved impunity. Even a few well-publicised cases could discourage physicians from participating in torture, especially if catalogued in a comprehensive web-based archive of such cases with source material.¹⁴ Individual doctors can support this effort by thoroughly documenting medical evidence of torture. This documentation could help overcome the practical difficulties of identifying offending physicians and proving their complicity. Doctors can also encourage their professional associations,

	Adopted	Effective	Binding
Universal Declaration of Human Rights	1948	..	No
Geneva Conventions I, II, III, and IV	1949	1950	Yes
European Convention for the Protection of Human Rights and Fundamental Freedoms	1950	1953	Yes
International Law Commission Principles of International Law Recognised in the Charter of the Nürnberg Tribunal and in the Judgment of the Tribunal	1950	..	No
International Covenant on Civil and Political Rights	1966	1976	Yes
American Convention on Human Rights	1969	1978	Yes
World Medical Association Declaration of Tokyo	1975	..	No
Additional Protocols I and II to Geneva Conventions	1977	1978	Yes
African Charter on Human and Peoples' Rights	1981	1986	Yes
UN General Assembly Resolution 37/194 on Principles of Medical Ethics	1982	..	No
UN Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment	1984	1987	Yes
Inter-American Convention to Prevent and Punish Torture	1985	1987	Yes
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment	1987	1989	Yes
Rome Statute of the International Criminal Court	1998	2002	Yes
Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment	2002	2006	Yes
UN Human Rights Council Resolution 10/24 on the Role of Health Professionals in Torture	2009	..	No
World Medical Association Council Resolution on Prohibition of Physician Participation in Torture	2009	..	No

Table: International laws, protocols, and declarations relevant to medical complicity in torture

regulators, and governments to initiate their own “War on Torture”, perhaps by explaining that the most basic human rights and society’s confidence in the medical profession depend on it.

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