# A grim dilemma: Treating the tortured prisoner

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Medical involvement with torture is prohibited by international law and professional associations, and yet sometimes it is the right thing for doctors to do, argue two bioethicists. Their timely paper in the Hastings Center Report comes as news of the trail leading to the death of Osama Bin Laden points to prisoners at Guantanamo Bay who were subject to "enhanced interrogation techniques," which many believe amounted to torture.

Despite its prohibition, torture remains widespread in more than a third of countries, according to data from Amnesty International cited in the article. And physicians and other medical personnel are implicated in at least 40 percent of cases, the article reports. Recently declassified documents from the Central Intelligence Agency on interrogation at Guantanamo Bay state, "OMS [Office of Medical Services] provided comprehensive medical attention to detainees . . . where Enhanced Interrogation Techniques were employed with high value detainees."

The dilemma physicians finds themselves in, according to authors Chiara Lepora and Joseph Millum, is that to care for tortured patients at the request of their torturers may "entail assisting or condoning terrible acts," but to refuse may in some cases mean abandoning a patient in need of a doctor's care or who desires such care. Chiara Lepora, M.D., is a visiting professor at the Korbel School of International Studies at the University of Denver who formerly worked for Doctors Without Borders as physician and emergency coordinator. Joseph Millum, Ph.D. has a joint appointment with the Clinical Center Department of

Bioethics and the Fogarty International Center at the National Institutes of Health.

While complicity is wrong, Lepora and Millum contend that there are degrees of complicity, and it can be outweighed by other factors, such as the tortured prisoner's desire for treatment. They argue that dilemmas facing physicians arise because different principles, such as refraining from doing harm and respecting a patient's wishes, come in conflict with each other. As a result, they write, "This dilemma is real and . . . sometimes the right thing for a doctor to do, overall, is to be complicit in torture."

The authors provide guidelines to physicians for minimizing complicity, including assessing the consequences of their actions for themselves, the patient, and possibly society, and attempting to discern and follow the requests of the patient. Physicians can minimize complicity by ensuring that their actions do not share the wrongful intentions of the torturers and that they perform the physician role in such a way at to "mitigate, prevent, or help redress acts of torture." For example, a physician could secretly collect data to be used by groups investigating torture. The authors note that physicians who have been coerced into assisting with torture have often been among the first sources for international tribunals redressing the torture.

Despite their recommendations for individual physicians, the authors do not endorse altering professional and legal prohibitions against physician involvement in torture, because these powerful condemnations offer aspiration to a world without torture and they can help doctors avoid involvement. But the authors do recommend a case-by-case approach to enforcement that considers the challenges and ethical complexities for physicians in countries where torture is widespread, as well as the willingness of some doctors to compromise themselves for the sake of their patients.

"Other things being equal, it is better for a physician not to be complicit in torture," the authors conclude. "But other things are rarely equal and ... a physician ought sometimes to accept complicity in torture for other moral reasons."

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