Medical Involvement in Enhanced Interrogation Techniques in American Detention Centres During the War on Terror: How Can Doctors Be Effectively Held to Account?

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Abstract

9/11 has had a profound effect on the way the US Administration has approached the issue of terrorism. The War of Terror has led to the introduction of the controversial enhanced interrogation techniques (EITs) that have raised the question of legality. The US Administration needed to change the perception of EITs from what could be classified as torture or other criminal and unlawful acts, to interrogation methods that were 'safe, legal and effective.'[1] In order to do so, the US Administration engaged medical professionals who then became involved with every aspect of EITs, from designing to implementing them. However, medical professionals, who are subject to different laws and medical professional norms, may have different duties than other actors, and as such, face disciplinary, civil and criminal consequences for their involvement. Because of this risk, and to encourage their assistance, the US Administration has argued that medical professionals in American detention centres are not in a fiduciary relationship with detainees (as patients) and where they are, their duties towards the state would override their medical duties. This thesis engages with these specific claims regarding doctors, arguing that the US Administration is legally wrong on both counts and that there is much greater scope than is generally recognised for holding medical professionals accountable in the US courts in both criminal and civil law, and disciplinary proceedings. Further, this thesis argues that establishing the existence of a fiduciary relationship between medical professionals and detainees can play a key role in improving prospects of success in many of these legal avenues, as well as opening up the possibility for such claims in tort as a claim for breach of the fiduciary relationship.

[1] Jay S. Bybee, Memorandum for Alberto R. Gonzales (2002); John C. Yoo, 'Memorandum to William J. Haynes II' (2003).

Declaration

I declare that this thesis has been submitted to the University of Kent for the degree of PhD and has not been submitted in any capacity for any other degree or certification. I similarly declare that all work appearing in this thesis is my own unless otherwise explicitly stated through reference or acknowledgement.

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List of Abbreviations

BSC Behavioural Science Consultants

BSCT Behavioural Science Consultants Team

CIA Central Intelligence Agency

EIT Enhanced Interrogation Techniques

EMTALA Emergency Medical Treatment and Labour Act of 1986

FTCA Federal Tort Claims Act 1946

HIPAA Health Insurance Portability and Accountability Act of 1996

HVD High-Value Detainees

ICRC International Committee of the Red Cross

IMAP Institute on Medicine as a Profession

MPC Model Penal Code

NCCHC National Commission on Correctional Health Care

OLC Office of Legal Counsel

OMS Office of Medical Services

OSF Open Society Foundations

PHR Physicians for Human Rights

POW Prisoners of War

UN CAT UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984

WCA War Crimes Act (US) 1996

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INTRODUCTION

On 14 September 2001, three days after the 9/11 terror attacks, the former president of the United States, George W. Bush, declared a national emergency. He justified the declaration with reference to the terrorist attacks on the World Trade Centre, Pentagon and Shanksville, PA, and 'the continuing and immediate threat of further attacks on the United States',[1] an argument that was subsequently used to authorise aggressive counter-terrorism policies. On 17 September 2001, George W. Bush signed a Memorandum of Notification equipping the CIA with 'broad authority to render individuals who pose continuing or serious threats of violence or death to US persons or interests or those who are planning terrorist attacks.'[2] A few days later, on 25 September 2001, John Yoo, the Deputy Assistant Attorney General of the Office of Legal Counsel, issued a memorandum to Timothy Flanigan, the Deputy Counsel. Yoo emphasised the quasi-omnipotence of presidential power, including that US Congress could not 'place any limits on the President's determinations as to any terrorist threat, the amount of military force to be used in response, or the method, timing, and nature of the response. These decisions, under [the] Constitution, are for the President alone to make.'[3] This memorandum alleged a *carte blanche* for the President to decide on the response to the terror threat, even if that meant disregarding US Congress, domestic law, and international law obligations. The memorandum was followed by subsequent legal opinions and memoranda[4] concerning the use of torture and involvement of medical professionals that require further consideration. Ultimately, in February 2002, Bush pronounced that the detainees held at Guantanamo Bay and other American

[1] George W. Bush, 'Declaration of National Emergency by Reason of Certain Terrorist Attacks' (14 September 2001).
[2] Central Intelligence Agency, 'Comments on the Senate Select Committee on Intelligence Report on the Rendition, Detention, and Interrogation Program' (27 June 2013). Section 1, Conclusion 1; Senate Select Committee on Intelligence, 'Committee Study of the Central Intelligence Agency's Detention and Interrogation Program' (3 December 2014) 11.
[3] John C. Yoo, 'Memorandum to Tim Flanigan, The President's Constitutional Authority to Conduct Military Operations Against Terrorist and Nations Supporting Them' (25 September 2001).
[4] ibid. George W. Bush, 'Memorandum to Vice President, Secretary of State, Secretary of Defence, *et.al*., Re: Humane Treatment of al Qaeda and Taliban Detainees' (7 February 2002); Jay S. Bybee, 'Memorandum to Alberto R. Gonzales, Standards for Conduct for Interrogation under 18 U.S.C. 2340 - 2340A' (1 August 2002).

detention centres, used for the purposes of the War on Terror, were unlawful war combatants and stripped them of any legal protection under international law.[5]

Subsequently, news of the use of torture and other cruel, inhuman or degrading treatment or punishment in American detention centres begun to circulate international media. In response, the US Administration confirmed that the detainees at American detention centres were subject to various interrogation methods, i.e., enhanced interrogation techniques (EITs). The US Administration presented EITs as 'safe, legal and effective'[6] and denied that they constituted torture. To guarantee that EITs were accepted as lawful, the US Administration controversially re-interpreted the legal definition of torture under domestic legislation.[7] To ensure the effectiveness of the interrogation techniques, the US Administration engaged medical professionals to safeguard the interrogations,[8] and to work on developing new EITs or 'improving' existing EITs.[9]

However, it did not take long for the true meaning of those roles to become apparent. 'Improving the effectiveness' of the interrogation methods turned out to be a euphemism for designing and developing EITs that had the effect of intensifying the pain and suffering of detainees.[10] The phrase 'ensuring safety' was used to describe the prevention of long-lasting effects of interrogation and the provision of medical assistance in the case of emergencies during interrogations.[11] Consequently, medical involvement in interrogations in American detention centres became a subject of worldwide concern. Many human rights non-governmental organisations shed light on the degree of medical

[5] George W. Bush, 'Memorandum to Vice President, Secretary of State, Secretary of Defence, *et.al*., Re: Humane Treatment of al Qaeda and Taliban Detainees' (7 February 2002) 1.
[6] Dick Cheney, Richard B. Cheney and Liz Cheney, *In My Time: A Personal and Political Memoir* (Threshold Editions: New York, 2011) 363.
[7] Jay S. Bybee, 'Memorandum to Alberto R. Gonzales, Standards for Conduct for Interrogation under 18 USC 2340 - 2340A' (1 August 2002) 22. Concerning the controversy around this, see: Manfred Nowak, 'What Practices Constitute Torture? US and UN Standards' (2006) 28 *Human Rights Quarterly* 809; Robert K. Goldman, 'Trivialising Torture. The Office of Legal Counsel's 2002 Opinion Letter and International Law against Torture' (2004) 12 *Human Rights Brief* 1; Jason Ralph, *Law, War and the State of American Exception* (Oxford University Press: Oxford, 2012); Louis-Philippe F. Rouillard, 'Misinterpreting the Prohibition of Torture Under International Law: The Office of Legal Counsel Memorandum' (2005) 21 *American University International Law Review* 9.
[8] ibid.
[9] ibid.
[10] Nathaniel Raymond *et al*, 'Experiments in Torture: Evidence of Human Subject Research and Experimentation in the "Enhanced" Interrogation Program' (Physicians for Human Rights, 2010) 8.
[11] ibid 8-9.

involvement.[12] Similarly, numerous academic commentators debated relevant legal and medical professional norms.[13] However, the literature failed to explain the variety of avenues for legal recourse available to challenge the use of the EITs and to engage with how these could be used. Despite the growing focus on the involvement of medical professionals in EITs over recent years, their involvement did not cease. Furthermore, as President Trump has expressed his support for the use of torture, the practice of controversial EITs in American detention centres will likely continue.[14] This raises the question of whether and how medical professionals could be held accountable for their involvement.

Why the Accountability of Medical Professionals for their Involvement in EITs is an Issue?

The US Administration has argued that actors involved in the use of EITs in American detention centres can never be held liable for their involvement as EITs were legal practices.[15] Further, to protect medical professionals from accountability for their wide-ranging involvement in EITs, the US Administration has argued that such liability is hindered by the lack of a fiduciary relationship with detainees and the duties that they simultaneously owe as soldiers. Using these arguments, the US Administration aimed to protect medical professionals involved from the type of legal accountability that normally flows from the breach of the fiduciary relationship, a legal relationship that carries the highest standard imposed by law.[16] As such, the US Administration correctly recognised that the unique nature of the medical profession required a different approach to justifying their involvement

[12] See for example: Physicians for Human Rights, Human Rights Watch, Amnesty International.
[13] For example: Steven H. Miles, *Oath Betrayed, Torture, Medical Complicity, and the War on Terror* (Random House: New York, 2006); Marjorie Cohn (eds.), *The United States and Torture: Interrogation, Incarceration, and Abuse* (New York University Press: New York, 2011); Michael Welch, 'American 'Painology' in the War on Terror: A Critique of "Scientific" Torture' (2009) 13 *Theoretical Criminology* 451; Myles Balfe, 'Why Did US Healthcare Professionals Become Involved in Torture During the War on Terror?' (2016) 13 *Journal of Bioethical Inquiry* 449; Abraham Halpern, John Halpern and Sean Doherty, 'Enhanced Interrogation of Detainees: Do Psychologists and Psychiatrists Participate?' (2008) 3 *Philosophy, Ethics, and Humanities in Medicine* 21.
[14] Matthew Weaver and Spencer Ackerman, 'Trump Claims Torture Works but Experts Warn of its "Potentially Existential" Costs' *The Guardian* (26 January 2017).
[15] See for example: Barack Obama, 'Statement on Release of OLC Memos' (16 April 2009).
[16] Mark Rodwin, *Medicine Money and Morals: Physician's Conflict of Interest* (Oxford University Press: New York, 1993); Deborah A. DeMott, 'Beyond Metaphor: An Analysis of Fiduciary Obligation' (1988) *Duke Law Journal* 879; Eileen A. Scallen, 'Promises Broken vs. Promises Betrayed: Metaphor, Analogy, and the New Fiduciary Principle' (1993) *University of Illinois Law Review* 897.

and precluding their legal accountability. Indeed, as Michael L. Gross, a political ethicist, proposes, the question of medical professionals' legal responsibility, focusing on the criminal responsibility only, for their involvement in such criminal conduct as torture is a two-stage question.[17] First, one has to consider whether the use of such acts could be justified *per se* under the criminal law, and second, whether the medical professionals' involvement can be justified, considering the nature of the medical profession. This approach reflects the special status of the medical profession, including the fiduciary relationship and the associated duties.

This thesis engages with these specific claims regarding medical professionals, arguing that the US Administration is legally wrong on both counts and that there is much greater scope than is generally recognised for holding medical professionals accountable in the US courts in both criminal and civil law, and disciplinary proceedings. Further, it argues that establishing the existence of a fiduciary relationship between medical professionals and detainees can play a key role in improving prospects of success in many of these legal avenues, as well as opening up additional avenues for legal recourse for breach of the fiduciary relationship. While, to date, the medical professionals have not been held to account for their involvement in torture in the context of the War on Terror, there is still some scope for change if the law is correctly interpreted and applied, and the necessary evidence is collected. To ensure adequate consideration of the issue requires a more detailed and nuanced analysis of both the fiduciary relationship and dual loyalties of medical professionals in American detention centres than is currently available in the existing literature.

Understandably, this reluctance to hold medical professionals accountable has many sources. First, it may be the case that some EITs do not amount to torture. It follows that, if EITs do not amount to torture, medical professionals (or anyone involved in the administration of EITs for that matter) could not be held accountable for torture. This narrow approach draws a line in the sand, either medical professionals are liable for torture or have no liability at all. It neglects the fact that the acts could

[17] Michael L. Gross, *Bioethics and Armed Conflicts. Moral Dilemmas of Medicine and War* (The MIT Press: London, 2003).

meet the legal definition of other criminal or unlawful acts that do trigger legal accountability. While there are certain benefits in focusing on and exploring the issues in the context of torture,[18] even if EITs do not meet the legal definition of torture, EITs may still amount to other cruel, inhuman or degrading treatment or punishment, they might take the form of other criminal conduct, including battery and assault, or even non-criminal conduct that might still trigger legal accountability. The question of whether EITs amount to torture has been the subject of significant attention from legal scholars,[19] hence this thesis does not place to scrutinise this question. This thesis does not challenge the classification of EITs as torture. However, it will briefly introduce it to illustrate the process by which torture has been normalised and to explain how medical professionals became entangled in their practice. In addition, this thesis discusses the benefits of widening the inquiry to cover other criminal and unlawful acts.

Second, medical involvement in the administration of EITs has been considered unsuitable for legal action.[20] Such a conclusion would highly likely be based on a consideration of the minor degrees of medical involvement in EITs. However, as further evidence of more severe degrees of medical involvement in EITs continues to come to light, and especially as some of the collected evidence is yet to be declassified,[21] the lack of legal accountability can no longer be justified. Chapter One assesses medical professionals' involvement in EITs, presenting the taxonomy of various kinds of medical involvement in EITs that allows us to distinguish between different degrees of wrongdoing. The taxonomy shows that not all medical involvement in EITs can be treated as insignificant and that even less serious forms of involvement may be sufficiently culpable to merit some form of sanction.[22]

[18] For example, courts can prosecute the crime of torture using the mechanism of universal jurisdiction. See Chapter Seven, Section 5.2.
[19] Vincent Iacopino and Stephen N. Xenakis, 'Neglect of Medical Evidence of Torture in Guantanamo: A Case Series' (2011) 8 *PLoS Medicine* 4; Leonard S. Rubenstein and Stephen N. Xenakis, 'Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees' (2010) 304 *Journal of the American Medical Association* 569; Anne Daugherty Miles, 'Perspectives on the Senate Select Committee on Intelligence (SSCI) "Torture Report" and Enhanced Interrogation Techniques: In Brief' (2015).
[20] See for example: Barack Obama, 'Statement on Release of OLC Memos' (16 April 2009).
[21] See: Senate Select Committee on Intelligence, 'Committee Study of the Central Intelligence Agency's Detention and Interrogation Program' (3 December 2014) 9. Chapter One, Section 3.4.
[22] This taxonomy is also used to analyse the issue of fiduciary relationship and the dual loyalties challenge.

This offers a clear basis for a critical and nuanced analysis of when a fiduciary relationship can be established and when the dual loyalties clash. The subsequent analysis follows to determine what kind of liability may be owed in relation to different conduct. Despite the general lack of accountability, during the second half of 2017, some progress could be seen with litigation brought against medical professionals involved in EITs emerging from civil courts. In particular, the US District Court of the Eastern District of Washington refused to dismiss a 2017 lawsuit (as other previous lawsuits have) which was subsequently settled out of court.[23] No other legal proceedings have been successful to date. As many other cases have been thrown out at an early stage on the grounds of the national security imperative,[24] the issues explored in this thesis are yet to be tested in court.

Third, the existing accountability apparatus (whether civil, disciplinary or criminal) have not been fully tested due to flawed legal analyses and the lack of political will to address the flagrant breaches of the law. The lack of political will to hold anyone involved in EITs (and not just medical professionals) accountable became policy during the Administration of George W. Bush, Barrack Obama, and continues under Donald Trump. Under Bush, the lack of accountability was to be expected. EITs were authorised by his administration, rationalised by an apparent threat to national security. Despite condemning the use of EITs, Obama did little to ensure that those participating in their use were held accountable.[25] Trump's support of the use of torture suggests that the chances of such proceedings being brought forward during his administration are extremely slim. Furthermore, Trump reversed Obama's decision to close Guantanamo Bay;[26] this suggests the possibility of its continued use as a detention centre, and as a place to conduct EITs on detainees.

[23] See: *Suleiman Abdullah Salim, et al.* v *James E. Mitchell and John Jessen*, 2:15-CV-286-JLQ.
[24] See for example, Jay S. Bybee, Memorandum for Alberto R. Gonzales (2002) 3.
[25] John O. Brennan, 'Statement on SSCI Detention and Interrogation Program' (11 December 2014).
[26] White House, 'Presidential Executive Order on Protecting America Through Lawful Detention of Terrorists' 30 January 2018.

Fourth, and specific to the case of medical professionals, the reason medical professionals are not held accountable is derived from a general acceptance of the US Administration's original arguments that first enabled medical professionals' involvement in EITs and which also protect them from accountability. First, the US Administration argues that medical professionals in American detention centres should not be perceived as medical professionals with fiduciary duties towards their patients (detainees).[27] Second, it argues that even if the medical professionals have some duties towards the detainees (patients), their duties towards the state would override any medical duties.[28] These arguments are indeed paramount. Medical professionals are bound by many different legal and professional duties. As such, the arguments used to enable medical involvement in EITs differ from the rationale for such involvement by other actors, such as CIA interrogators. In the case of such medical involvement, the questions that must be asked are, first, whether the use of torture (and other criminal or unlawful acts) could be justified,[29] and second, whether the involvement of medical professionals is warranted.[30]

The US Administration uses these two arguments to address the question of whether medical involvement could be warranted, helping to accommodate and justify the involvement of medical professionals. This thesis attacks this justification while accepting that there would still be formidable hurdles to bringing doctors to account at the political level. As such, it is making an important contribution by toppling this one hurdle. In this light, this thesis aims to explore how medical professionals can effectively be held accountable for their involvement in EITs. To engage with this question, this thesis challenges the two main arguments specific to the medical professionals that enabled medical involvement in the EITs and helped to protect them from accountability.

[27] US Department of Defence, 'Instruction 2310.08E, Medical Program support for detainee operations' (6 June 2006).
[28] ibid.
[29] The thesis does not engage with the question whether torture could ever be justified.
[30] Michael L. Gross, *Bioethics and Armed Conflicts. Moral Dilemmas of Medicine and War* (The MIT Press: London, 2003).

As such, this is the first study to undertake an in-depth analysis of the US Administrations' arguments enabling and justifying the involvement of medical professionals in EITs and exploring the weakness of such arguments. This study aims to contribute to the underrepresented but growing area of research on medical involvement in EITs.[31] To do so it demonstrates that the summary justification provided by the US Administration is flawed and is capable of rebuke, thus opening the door for disciplinary, civil or criminal proceedings against the medical professionals involved. More specifically, this thesis challenges the two arguments advanced by the US Administration that, while they have not gained much attention in academic debates, are the cornerstone of the justification of medical involvement in torture or other criminal and unlawful acts.[32]

The analysis in this thesis takes into consideration the distinction made by the US Administration, between health care personnel (ordinary medical professionals) who were present to provide medical assistance to detainees[33] and behavioural science consultants (the BSCs) who were engaged to 'provide consultative services to authorised law enforcement or intelligence activities.'[34] This distinction is relevant as the US Administration suggests that the duties required from, and medical professional norms applicable to, the BSCs vary significantly, ultimately placing them above the law and medical professional norms. This thesis challenges this by focusing on the relationship between medical professionals and detainees and corresponding duties.

The findings of this research in response to the two arguments, centring around the existence of the fiduciary relationship and dual loyalties, should make an essential contribution to the field of law and medical ethics concerning the perception of medical professionals in the military and their duties

[31] For example: Steven H. Miles, *Oath Betrayed, Torture, Medical Complicity, and the War on Terror* (Random House: New York, 2006); Cohn (n 13); Michael Welch, 'American 'Painology' in the War on Terror: A Critique of "Scientific" Torture' (2009) 13 *Theoretical Criminology* 451; Myles Balfe, 'Why Did US Healthcare Professionals Become Involved in Torture During the War on Terror?' (2016) 13 *Journal of Bioethical Inquiry* 449; Abraham Halpern, John Halpern and Sean Doherty, 'Enhanced Interrogation of Detainees: Do Psychologists and Psychiatrists Participate?' (2008) 3 *Philosophy, Ethics, and Humanities in Medicine* 21.

[32] The two arguments are that medical professionals in American detention centres do not have any fiduciary duties towards the detainees, and any dual loyalties would have to be resolved in favour of the military obligations.

[33] See: Chapter Two, Section 4 for a detailed analysis.

[34] Instruction (n 27) 2.

towards the state and towards detainees (patients). First, this thesis engages with the issue of fiduciary duties and how they are established or imposed. It scrutinises scenarios where the courts are likely to impose the fiduciary relationship to address the power imbalance or to burden the party creating the peril to another. This is an important part of this research as detecting the presence of a fiduciary relationship will help to trigger legal consequences, especially in civil or disciplinary proceedings. Even though the US Administration has significantly narrowed the number of cases where it accepts the existence of the fiduciary relationship, the analysis in this thesis shows how this can be challenged, proposing clear guidance for dealing with such cases.

Second, this thesis engages with the underrepresented questions of dual loyalties. The fact that this is often considered summarily leads to flawed conclusions. It demonstrates that dual loyalties are case-specific and need to be assessed in each individual case. As in the case study of this thesis, the mere fact that medical professionals are embedded in the military and have duties towards the state and towards the patients does not mean that the duties must clash, forcing them to choose between the duties. Also, as explained in the context of torture or other criminal conduct, such a clash does not occur. Further, in the case of non-criminal conduct, the clash of duties does not have to occur and even if it does, military duties would not always prevail.

This thesis explores the fiduciary relationship and its importance in holding medical professionals to account. In doing so, it contributes to the underrepresented argument that a claim for breach of the fiduciary relationship may improve the chances of holding medical professionals accountable for their involvement in EITs.[35] Among others, the fiduciary relationship imposes a higher moral and legal standard for medical professionals to uphold, on top of any other legal duties they would already have had, and a lower threshold for being held accountable for a breach, as compared to, for example, the

[35] David Tan, 'Sexual Misconduct by Doctors and the Intervention of Equity' (1997) 4 *African Journal of Laboratory Medicine* 243; Suzanne Ost, 'Breaching the Sexual Boundaries in the Doctor-Patient Relationship: Should English Law Recognise Fiduciary Duties?' (2016) 24 *Medical Law Review* 2.

criminal or civil threshold. Because of that, the focus on the fiduciary relationship provides more options and improve chances ensuring accountability.

The Rationale for the Focus on the American Detention Centres

This thesis focuses on American detention centres because of the growing evidence of medical involvement in the 'War on Terror'-related EITs. Medical involvement is systematic and widespread in EITs utilised at American detention centres, and hence, is a worthy subject of analysis. President Trump's decision to keep Guantanamo Bay open may suggest that such techniques will continue to be used against detainees. Furthermore, the issues explored in this thesis, and especially surrounding the concept of fiduciary relationships and dual loyalties, may also be relevant in response to the occurrence of state authorised medical involvement in criminal and unlawful acts in other situations or states.

Understandably, medical involvement in criminal and unlawful acts, including torture, is not a phenomenon exclusive to the 'War on Terror.' A recent project of Steven H. Miles records the occurrence of such medical involvement around the world and the states' response to these acts. It is clear from Miles' research that the failure to hold medical professionals accountable for their involvement in such criminal and unlawful acts is widespread. He records that there are only a few states that have successfully conducted, predominately criminal but also disciplinary, proceedings in such cases, notably Brazil, Chile, Argentina, Uruguay, Italy, and Rwanda.[36] In Turkey, Greece, the UK, India, and Pakistan, medical professionals have been prosecuted, however, the practice to routinely hold medical professionals to account is not well established.[37]

In Brazil, medical professionals were widely involved in the practice of torture under Getúlio Vargas, and during the military dictatorship between 1964 and 1985.[38] Most of the cases related to medical

[36] The Doctors Who Torture Accountability Project. Available at: https://www.doctorswhotorture.com/.
[37] ibid.
[38] Fred Charatan, 'Brazil Challenges Doctors Accused of Torture' (1999) 318 *British Medical Journal* 757.

professionals falsifying death certificates and certifying their fitness to withstand torture. Other examples included failure to administer essential treatment and advising military personnel on how to hide the signs of torture.[39] Twenty-Six medical professionals, who were involved in torture during the military dictatorship, faced disciplinary proceedings through the Brazilian medical association. An amnesty against criminal proceedings prevented the victims and their families from initiating such proceedings.

In Argentina, medical professionals assisted in torturing prisoners during the Proceso de Reorganización Nacional military regime, 1976-1983 (so-called Dirty War). The Buenos Aires Central Prison Hospital and the Alejandro Posadas National Hospital were designated and used as secret detention centres where torture was widely used.[40] It was further alleged that some of the medical professionals raped and sexually abused female inmates, conducted human experimentation without consent or were involved in kidnappings of children for the black market.[41] The medical professionals involved were prosecuted in domestic criminal courts for their involvement in torture, including for failure to report torture or facilitating it.[42] Some of the medical professionals had their licences revoked or were censured by the University Ethics Conference.[43]

In Chile, medical professionals assisted the Pinochet government with torture. In similar circumstances to those that currently exist in the US, the Pinochet government introduced measures that discharged medical professionals from responsibilities for adhering to medical professional guidelines.[44] Medical professionals were not required to join the Chilean College of Physicians and Surgeons and therefore were not subject to its disciplinary tribunal.[45] Even though more than 50

[39] Joan Dassin, *Torture in Brazil: A Shocking Report on the Pervasive Use of Torture by Brazilian Military Governments, 1964-1979* (University of Texas Press: Austin, 1998) 33-38.
[40] ibid.
[41] ibid.
[42] Andrew Perechocky, 'Los Torturadores Medicos: Medical Collusion with Human Rights Abuses in Argentina, 1976–1983' (2014) 11 *Journal of Bioethical Inquiry* 549.
[43] National Commission on Disappeared People, *Nunca Más: The report of the Argentine National Commission on the Disappeared* (Farrar Straus Giroux/Index on Censorship: New York, 1986).
[44] Brian Goldman, 'Chilean Medical College Battling Doctor Participation in Torture' (1985) 15 *Canadian Medical Association Journal* 1414-6.
[45] ibid.

medical professionals were known to have been involved in torture, very few have been suspended or expelled by the Chilean Medical Association.[46]

Medical professionals were involved in the Rwandan genocide of the Tutsi people in 1994.[47] Several medical professionals ordered killings and/or killed patients in hospitals.[48] Among others, Dr Charles Twagira, Dr Sosthene Munyemana, Dr Clement Kayishema, Dr Eliezer Niyitegeka, Dr Gerard Ntakirutimana, Dr Vincent Bajinya, and Dr Eugene Rwamucyo faced criminal prosecutions for their involvement.[49]

The above cases demonstrate that medical professionals' engaged in such criminal acts can be successfully prosecuted in domestic courts, even if authorised by the state. Nonetheless, such prosecutions are rare and most of the aforementioned cases took place during the second half of the 20th century. Nonetheless, there are also other, more modern cases. Indeed, British medical professionals have been accused of being complicit in torture on several occasions throughout the 20th and 21st century, notably, in Kenya, Cyprus, Northern Ireland, and most recently in Iraq.[50] In the UK, a small number of prosecutions have been brought against medical professionals involved in torture.[51] However, this is far from established practice.

This thesis focuses on avenues that are open for legal recourse against medical involvement in American detention centres, as such, it explores only the US domestic legal avenues. By focusing on domestic proceedings exclusively, this thesis will engage with arguments on how to ensure greater accountability for a wide range of involvement of medical professionals undertaking various roles in American detention centres (rather than focus on the those most responsible for the acts as would be the case in international law proceedings). This thesis does not engage with legal proceedings outside of the US, although it does recognise that these do exist. Medical professionals, who have been

[46] ibid.
[47] Marie-Care Harris, 'Doctors Implicated in Tutsi Genocide' (1996) 347 *The Lancet* 684.
[48] Torben Ishoy, 'Doctors and Genocide' (1995) 346 *The Lancet* 8974, 577.
[49] ibid.
[50] The Doctors Who Torture Accountability Project. Available at: https://www.doctorswhotorture.com/.
[51] ibid.

involved in EITs outside of the US, may be held to account under the penal code of the countries where the criminal conduct took place, most notably in Lithuania, Italy, Poland, Romania, Afghanistan and Iraq. The issue of the use of EITs in these countries has not been considered by their respective domestic criminal courts, but by the European Court of Human Rights (ECtHR),[52] and in the case of Afghanistan by the International Criminal Court (ICC).[53] Indeed, the very involvement of the ECtHR and the ICC in these cases suggests that the domestic courts in these countries did not engage with, or failed to provide the victims with redress.

Understandably, medical professionals could be prosecuted by relevant international criminal tribunals. However, at this stage, such proceedings relating to the use of EITs in American detention centres are unlikely. No tribunal would have the requisite jurisdiction to look into the acts. The only permanent court in existence, namely, the ICC, does not have the territorial jurisdiction over the acts of medical professionals in American detention centres in the US or Iraq, as neither is a party to the Rome Statute. Similarly, the ICC could not use personal jurisdiction over US citizens for the same reason. However, the ICC is already conducting a preliminary examination of similar crimes alleged to have taken place in British detention centres in Iraq, an examination that also implicates medical professionals. The European Centre for Constitutional and Human Rights claims that over 60 medical professionals were complicit in torture at military camps in Iraq by monitoring and failing to stop and/or report it.[54] These accusations were incorporated in communications that were sent to the Office of the Prosecutor (OTP) to the ICC and have led the OTP to open a preliminary examination into alleged war crimes committed by British nationals in the context of the Iraq conflict and occupation

[52] See: European Court of Human Rights cases of *Al Nashiri* v *Poland* (2014) ECHR 231; *Abu Zubaydah* v *Poland* (2014) ECHR; *Al Nashiri* v *Romania* (2018) ECHR 214. See also: *El-Masri* v *the former Yugoslav Republic of Macedonia* (2012) ECHR 2067; *Nasr and Ghali* v *Italy* (2016) ECHR 210; *Abu Zubaydah* v *Lithuania* (2018) ECHR 446

[53] ICC, Afghanistan: ICC Appeals Chamber authorises the opening of an investigation (5 March 2020). Available: https://www.icc-cpi.int/afghanistan.

[54] European Centre for Constitutional and Human Rights and Public Interest Lawyers, 'Communication to the Office of the Prosecutor of the International Criminal Court, The Responsibility of Officials of the United Kingdom for War Crimes Involving Systematic Detainee Abuse in Iraq from 2003-2008.'

from 2003 to 2008.[55] The preliminary examination continues in its early stages and there has been no confirmation whether official investigations and/or proceedings will be initiated. As British involvement in torture in Iraq is strongly associated with American involvement, any investigation is likely to lead to a formal inquiry by the ICC into the American military's involvement. The evidence submitted to the ICC is likely to implicate the US for its part in EITs.

Similarly, the decision of the ICC to consider the situation in Afghanistan may shed further light on the use of EITs (and potentially, the involvement of medical professionals).[56] Furthermore, as the ICC has jurisdiction over other countries where such American detention centres were placed, including, Poland, Romania, Lithuania and Italy, the ICC could exercise its territorial jurisdiction to investigate and prosecute acts committed in these jurisdictions, as long as other conditions for the ICC's engagement are fulfilled.

Another option for an international accountability mechanism would be for the UN Security Council to establish an ad-hoc tribunal, for example, to prosecute the atrocities perpetrated in due course of the War on Terror, including the medical professionals involved in the practice of EITs. Because the US, as a permanent member of the UN Security Council, has a veto, it would be able to block resolutions before the UN Security Council, such a resolution would highly likely fail.

Methodology and Data

The Methodological Approach

This thesis relies on doctrinal analysis. Pearce defines doctrinal research as 'research which provides a systematic exposition of the rules governing a particular legal category, analyses the relationship

[55] ICC, Prosecutor of the International Criminal Court, Fatou Bensouda, Re-opens the Preliminary Examination of the Situation in Iraq, 13 May 2014. Available at: https://www.icc-cpi.int/Pages/item.aspx?name=otp-statement-iraq-13-05-2014.

[56] ICC, Judgment on the Appeal Against the Decision on the Authorisation of an Investigation into the Situation in the Islamic Republic of Afghanistan, 5 March 2020. Available at: https://www.icc-cpi.int/Pages/record.aspx?docNo=ICC-02/17-138.

between rules, explains areas of difficulty and, perhaps, predicts future developments.'[57] Among others, doctrinal analysis involves organising case law into coherent categories and concepts, identifying precedent and emerging law, and discerning between settled law and a preferred approach. Hutchinson and Duncan further suggest that this approach involves 'assembling relevant facts, identifying the legal issues, analysing the issues with a view to searching for the law, (…) synthesising all the issues in context, and coming to a tentative conclusion.'[58] The doctrinal analysis is the right choice for this thesis as it aims to analyse the existing law and explore the avenues for legal recourse available.

Data Sources

This thesis relies upon a range of primary and secondary sources, including reports on the use of EITs in American detention centres (in general and with a specific focus on medical professionals), and academic literature, both books and journals. The rationale for focusing on the existing evidence was also to identify the weaknesses of the evidence available to date that will ultimately have an impact on how medical involvement in EITs is being perceived. The lack of reliable and robust evidence weakens the chance of any legal proceedings being brought against medical professionals involved in EITs. This thesis aims also to highlight where there are gaps in the evidence which will need to be addressed in order to ensure the success of any future legal proceedings.

There are certain limitations to the research that should be acknowledged here. First, evidence continues to be limited. The thesis is based on evidence collated by governmental and non-governmental actors, working under significant practical constraints. For these reasons, it has not been based on a comprehensive understanding of medical involvement in EITs in American detention centres. It is beyond the scope of this study to obtain and examine further evidence of the use of EITs

[57] Dennis Pearce, Enid Campbell and Don Harding, *Australian Law Schools: A Discipline Assessment for the Commonwealth Tertiary Education Commission* (Australian Government Publishing Service, 1987) cited in Terry Hutchinson, *Researching and Writing in Law* (Reuters Thomson, 2010) 7.
[58] Terry Hutchinson and Nigel Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research' (2012) 17 *Deakin Law Review* 83.

or the evidence of medical involvement in EITs. It is accepted that for the disciplinary, civil or criminal proceedings to be successful, further evidence will be necessary.

There are very few reports detailing the use of the enhanced interrogation techniques (EITs) in US military and intelligence detention centres (American detention centres) and even fewer which deal with the specific issue of medical involvement. This is caused by a general lack of transparency in the American detention centres. American detention centres, including Guantanamo Bay, are not accessible to external investigators, and the majority of the documentation surrounding their operation remains confidential or heavily redacted. As a result, the true scale of wrongdoing cannot be adequately measured. Among other issues, all requests for access to such detention centres made by the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, a UN special procedure mechanism, have been denied by the US Administration.[59]

Despite these limitations, empirical research conducted by several governmental and non-governmental organisations has proved to be an invaluable source of information. This includes government reports, reports of non-governmental organisations,[60] and reports, briefings and statements of international institutions.[61] This thesis further relies on academic literature, both books and journals, on medical involvement in EITs in American detention centres and general literature on the issue of fiduciary relationship and dual loyalties.

Chapter Outline

The work proceeds as follows. Chapter One summarises what is already known about the involvement of medical professionals with EITs in American detention centres, highlighting any gaps in our knowledge. Firstly, it explains what EITs are, why the US Administration uses that term and why this

[59] Inter-American Commission on Human Rights, 'Statement of the United Nations Special Rapporteur on torture at the Expert Meeting on the situation of detainees held at the US Naval Base at Guantanamo Bay (3 October 2013).
[60] Physicians for Human Rights, International Red Cross, Institute on Medicine as a Profession and the Open Society Foundations, American Civil Liberties Union, Amnesty International
[61] For example, the United Nations Committee on Torture, the Office of the High Commissioner for Human Rights, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

thesis has likewise adopted it. This thesis argues that it is important to move away from a framework that focuses on torture. This approach allows consideration of the different elements of these practices, including other criminal or unlawful acts, and those which offend against disciplinary norms. By disaggregating the elements of torture in this way, it aims to explore a range of avenues for ensuring legal and professional accountability with regard to the broad range of activities undertaken by medical professionals in American detention centres, and especially in situations where the EIT falls short of the legal definition of torture. Secondly, by relying on four major reports, it explains what is known about medical involvement in EITs, again recognising any gaps in the evidence available and the challenges they pose for this research. Thirdly, it sets out the range of different kinds of conduct in which doctors have been involved, categorising them in a taxonomy, which will be used in the subsequent chapters to aid with the analysis of the US Administration's arguments justifying medical professionals involved in administering EITs.

Having established that medical involvement in EITs was critical to the US Administration, Chapter Two moves on to set out the arguments it deploys to justify the use of EITs in detention centres. These contentious and contested arguments operated to normalise the use of torture and EITs. They have, however, been well explored in the literature on the so-called 'War on Terror', which has largely ignored the way in which the US Administration sought to redefine the duties of medical professionals in American detention centres to enable their involvement while hindering their legal accountability. This chapter explores these arguments, analysing them in the context of the US Administration's attempts to reduce the protections offered to detainees more generally. This thesis draws out two aspects of the US Administration's arguments which it considers to be both wrong and of particular importance: the fiduciary relationship and the concept of dual loyalties. First, it presents how the US Administration has sought to strip detainees of any legal protections, including protections prohibiting acts such as torture and other criminal and unlawful. Second, it argues that the US Administration effectively normalised the use of torture and other criminal and unlawful acts which it describes as EITs. Third, it argues that the US Administration has redefined the medical duties of

medical professionals in American detention centres to repudiate the fiduciary relationship and override any duties towards the detainees.

This thesis then moves on to explore these twin arguments, relied upon by the US Administration, in more detail. In Chapters Three and Four, it deals with the fiduciary relationship. Chapter Three argues that the nature of the relationship between medical professionals and detainees in American detention centres is pivotal to many of the different types of legal accountability owed by medical professionals. The US Administration correctly recognises this. Indeed, the existence of a fiduciary relationship can strengthen existing legal claims or enable avenues of legal recourse that would not otherwise be available. In order to build this argument, this chapter sets out the existing US law on when a fiduciary relationship is owed and when it is not owed. It begins by discussing why the existence of the fiduciary relationship matters and examines the practical implications of the fiduciary relationship between medical professionals and patients. It then argues that the existence of a fiduciary relationship between medical professionals and detainees affects their duties towards the detainees and opens up avenues of legal actions that are otherwise not available. The chapter then sets out how a fiduciary relationship is attached under the US law and considers the limitations to such a relationship, including the limited circumstances in which such a duty is not owed by a medical professional to those encountered in their professional practice. It then examines, in cases where the fiduciary relationship is established, when such a duty comes to an end, and what that means for the potential accountability of the medical professionals.

Chapter Four tests the US Administration's denial of the existence of a fiduciary relationship between medical professionals and detainees against the legal framework outlined in the previous chapter. First, this chapter discusses the nature of the relationship between medical professionals and detainees. This analysis takes into consideration two variables: first, the type of medical professional and, second, the type of conduct (relying on the taxonomy developed in Chapter One). It argues that the Administration's guidelines depart from US law and that, according to domestic law, a fiduciary relationship can be established or imposed between the different types of medical professionals and

detainees in American detention centres. This chapter then proposes how the fiduciary relationship can be attached to the different types of medical professionals, with a specific focus on cases where the courts can impose the fiduciary relationship in all the circumstances. Second, this chapter responds to the question of whether medical professionals could have developed a legitimate expectation that a fiduciary relationship does not exist on assurances given by the US Administration.

Chapters Five and Six challenge the second element of the US Administration's argument for why medical professionals in American detention camps are not legally liable for what would otherwise be criminal and unlawful conduct: the doctrine of dual loyalties. The argument proceeds in two stages, reflecting on the important distinction between those cases where the norms of appropriate medical conduct are breached in ways that are sufficiently serious potentially to attract criminal liability (Chapter Five) and conduct that may fall below this threshold but would nonetheless attract civil or disciplinary liability (Chapter Six). Chapter Five, having briefly reminded the reader of the meaning of the dual loyalties' doctrine and the role that it plays in the US Administration's claim, contests the presumption that medical and military duties are always and inevitably in conflict. First, it argues that, while, as a matter of empirical fact, medical professionals may sometimes perceive there to be such a conflict, this is due to a mistaken understanding of the relevant law, possibly influenced by a strong sense of institutional loyalty. Second, it argues that in many cases – where conduct amounts to criminal conduct – medical and military duties are coterminous as both doctors and soldiers share in a legal duty not to engage in them. As such, the dual loyalties doctrine does not and cannot offer a legal justification or excuse to these more serious forms of conduct.

Chapter Six moves on to focus on conduct that may fall short of the threshold of criminal acts but would nonetheless attract civil or disciplinary liability. Here, it analyses the concurrent duties that medical professionals may owe as doctors and as soldiers and identifies whether the dual loyalties conflict occurs. It concludes that only in exceedingly rare cases of minor involvement can the dual loyalties argument play a role in exculpating doctors from civil or disciplinary accountability. Where a dual loyalties conflict does arise, it challenges the argument that military duties would override

fiduciary duties. Rather, it argues that a claim of dual loyalties will rarely serve to excuse unlawful behaviour, as in most cases where a conflict exists, the fiduciary duty owed by a doctor to his or her patients would prevail.

Finally, Chapter Seven moves on to consider the legal and disciplinary avenues which are available for bringing medical professionals to account for their involvement in EITs. Before discussing the specific avenues, it sets out the major salient differences between the different kinds of action. It then moves on, first, to consider disciplinary proceedings, analysing four of the complaints made against medical professionals and the reasons for their failure. Second, it explores the civil routes towards accountability, focusing specifically on claims under the Alien Tort Statute, claims for medical malpractice, and claims for breach of the fiduciary relationship. In this section, it analyses the only relevant civil suit, *Salim* v *Mitchell*, which settled outside of court. Third, it explores options for criminal prosecutions in domestic courts in the US. Throughout, it argues that whilst the argument about establishing a fiduciary relationship was not central to the failures of the legal actions, relying on the existence of the fiduciary relationship between medical professionals and detainees is key to opening many of the legal avenues.

CHAPTER ONE: Mapping Medical Involvement in Enhanced Interrogation Techniques in American Detention Centres

1.Introduction

There are very few reports detailing the use of the enhanced interrogation techniques (EITs) in US military and intelligence detention centres (American detention centres), and fewer dealing with the specific issue of medical involvement. This is because of the lack of transparency in the American detention centres. American detention centres, such as Guantanamo Bay, are not accessible to external investigators, and the majority of the documentation surrounding their operation remains restricted or heavily redacted. However, despite high levels of secrecy, various documents and information have been disclosed or leaked into the public domain. The four most relevant reports are the International Committee of the Red Cross Report, the Physicians for Human Rights Report, the Task Force Report, and the Senate Select Committee on Intelligence Report; all of which are discussed in this chapter.

The central aim of this chapter is to summarise what is known about the involvement of medical professionals with EITs in American detention centres, highlighting any gaps in our knowledge. Firstly, the chapter explains what EITs are, why the US Administration uses that term and why this thesis follows the same categorisation (Section 2). It argues that it is important to move away from a framework that focuses on torture and to focus on the individual elements of these practices, including other criminal or unlawful acts. By disaggregating the elements of torture in this way, it becomes possible to explore a wider range of mechanisms for ensuring accountability for the broad range of activities undertaken by medical professionals in American detention centres, especially in circumstances where the EIT falls short of the legal definition of torture. Secondly, it explains what is known about medical involvement in EITs, recognising any gaps in the evidence available and the challenges they pose for this research (Section 3). This thesis focuses on four main reports on the involvement of medical professionals with EITs. It assesses the value of the evidence presented and

identifies any shortfalls that need to be addressed. Thirdly, it sets out the range of acts in which doctors have been involved, relying on the reports, introducing a taxonomy of the different types of conduct (Section 4). This taxonomy is then used in the subsequent chapters to support an analysis of the arguments used by the US Administration to enable and justify medical involvement in EITs.

2. What are Enhanced Interrogation Techniques and what is their Legal Classification?

EITs were approved by the George W. Bush Administration for use as part of the CIA's Detention and Interrogation Program, a rendition, detention, and interrogation programme used in the 'War on Terror' response.[1] They include such practices as stress positions, sleep deprivation, nudity, abdominal slaps, the facial hold, the facial slap, attention grasp,[2] cramped confinement, dietary manipulation, wall standing, walling, waterboarding, and water dousing.[3] EITs were subsequently revised, and as confirmed in a 2005 memorandum,[4] more intense techniques were approved, including:

> walling 20–30 times consecutively, abdominal slaps directed at the abdomen, stress positions including forcing a standing detainee to lean against a wall with his head while his hands are handcuffed in front of or behind him, water as cold as 41 degrees doused on the detainee through a nozzle for as long as 20 minutes (or up to 40 minutes at 50 degrees or 60 minutes at 59 degrees), "flicking" water at the detainee's face by use of the interrogator's finger to instil humiliation, sleep deprivation for up to 180 hours by forcing a detainee to stand with handcuffs attached to the ceiling and legs shackled to the floor or by shackling him to a small stool, and waterboarding through

[1] See Chapter Two, Section 3.
[2] 'This technique consists of grasping the individual with both hands, one hand on each side of the collar opening, in a controlled and quick motion. In the same motion as the gasp, the individual is drawn toward the interrogator.' Steven G. Bradbury, Memorandum to John Rizzo (10 May 2005)
[3] Nathaniel Raymond *et al*, 'Experiments in Torture: Evidence of Human Subject Research and Experimentation in the "Enhanced" Interrogation Program' (Physicians for Human Rights, 2010) 8.
[4] Steven G. Bradbury, 'Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques that May be Used in the Interrogation of a High-Value al Qaeda Detainee: Memorandum to John A Rizzo' (2005) 7. Thereafter 'OLC, Bradbury.'

> the pouring of water on a cloth over a detainee's face while inclined head down for up to 40 seconds.[5]

The US Administration classified EITs as safe, legal and effective,[6] although this classification was later successfully challenged by human rights experts and independent review mechanisms.[7] Such an analysis of the human rights experts often classifies EITs as torture. While the terms 'EIT' and 'torture' are often used interchangeably, torture is a separate legal term that has a precise legal definition (albeit one that may vary between jurisdictions). For the purposes of this thesis, the definition of torture will be taken from the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN CAT):

> 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.[8]

[5] Institute on Medicine as a Profession and OSF Joint Task Force Guantanamo Bay, 'Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror' (2013) 32 [internal citations omitted]. See also: Section 3.3. below.

[6] Jay S. Bybee, Memorandum for Alberto R. Gonzales (2002); John C. Yoo, 'Memorandum to William J. Haynes II' (2003).

[7] See: Senate Select Committee on Intelligence Report discussed in Section 2. See also: Anne Daugherty Miles, 'Perspectives on the Senate Select Committee on Intelligence (SSCI) "Torture Report" and Enhanced Interrogation Techniques: In Brief' (2015); Michael B. Mukasey, 'Opinion' *Wall Street Journal* (16 December 2014); Alfred McCoy, *A Question of Torture: CIA Interrogation, from the Cold War to the War on Terror* (Metropolitan Books: New York, 2006); Alex Bellamy, 'No Pain, No Gain? Torture and Ethics in the War on Terror' (2006) 82 *International Affairs* 121–148.

[8] Article 1(1) of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN CAT).

The UN CAT imposes an absolute ban on torture and states that there are '[n]o exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.'[9] Furthermore, international law regards the prohibition of torture as a human rights violation with the status of *jus cogens* (a peremptory norm), which places torture at the same level of seriousness as other crimes such as genocide, the war of aggression, and slavery.[10] While the precise meaning of *jus cogens* is disputed,[11] the status makes torture a non-derogable violation and so no exception to the prohibition is permitted.[12] As a result of its unique status, torture can never be legalised, authorised, or justified by a state.[13] Because the prohibition of torture is customary international law, it is binding and does not require ratification.[14] While a state would not usually be bound by the treaty if it had not ratified it, this is not the case so far as customary international law obligations are concerned. Furthermore, torture attracts universal jurisdiction.[15] Hence why it is beneficial to describe EITs as torture. However, where the legal definition of torture is not met, EITs may still amount to other criminal or unlawful acts. This analysis should not be ignored.

The United States ratified the UN CAT in 1994, however, it made a series of reservations[16] that significantly limits the scope of the obligations it places upon the United States.[17] The most significant reservation states that,

[9] UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN GA Res. 39/46, UN Doc. A/39/51 (1984). (later cited as UN CAT)
[10] Steven R. Ratner, Jason S. Abrams, James L. Bischoff, *Accountability for Human Rights Atrocities in International Law. Beyond the Nuremberg Legacy* (Oxford University Press: New York, 2010) 121.
[11] With a narrower meaning in Article 53 of the Vienna Convention and wider one claimed by many human rights organisations.
[12] Erika de Wet, 'The Prohibition of Torture as an International Norm of jus cogens and Its Implications for National and Customary Law' (2004) 15 *European Journal of International Law* 97.
[13] Marjorie Cohn (eds.), *The United States and Torture: Interrogation, Incarceration, and Abuse* (New York University Press: New York, 2011) 17.
[14] Marjorie Cohn, 'An American Policy of Torture' in Marjorie Cohn (ed.), *The United States and Torture: Interrogation, Incarceration, and Abuse* (New York University Press: New York, 2011) 5.
[15] Steven R. Ratner, Jason S. Abrams, James L. Bischoff, *Accountability for Human Rights Atrocities in International Law. Beyond the Nuremberg Legacy* (Oxford University Press: New York, 2010) 121-122.
[16] '"Reservation" means a unilateral statement, however phrased or named, made by a State, when signing, ratifying, accepting, approving or acceding to a treaty, whereby it purports to exclude or to modify the legal effect to certain provisions of the treaty in their application to that State.' Article 2(1)(d) of the 1969 Vienna Convention on the Law of Treaties.
[17] UN CAT, Reservations, United States of America.

> with reference to Article 1, the United States understands that, in order to constitute torture, an act must be specifically intended to inflict severe physical or mental pain or suffering and that *mental pain or suffering refers to prolonged mental harm caused by or resulting from (1) the intentional infliction or threatened infliction of severe physical pain or suffering; (2) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality; (3) the threat of imminent death; or (4) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality.*[18]

While the definition of torture at §2340(1) of the US Code broadly mirrors the UN definition, this reservation was an early indicator that the US wanted to have more discretion over the wording of the definition of torture and the scope of its application. However, following 9/11, the US Administration adopted a highly concerning (and contested) interpretation of §2340(1), aimed at allowing a higher threshold of pain or suffering for the elements of torture are proven, reinforcing but going far beyond the reservation to the UN CAT. This is discussed in Chapter Two.

The vast majority of the academic literature on the topic recognises that EITs used on detainees in American detention centres amount to torture under the UN CAT and the US Code's definitions of torture.[19] The US Administration[20] and several media commentators depart from this consensus to

[18] ibid. [emphasis added].
[19] See for example: Vincent Iacopino and Stephen N. Xenakis, 'Neglect of Medical Evidence of Torture in Guantanamo: A Case Series' (2011) 8 *PLoS Medicine* 4; Leonard S. Rubenstein and Stephen N. Xenakis, 'Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees' (2010) 304 *Journal of the American Medical Association* 569; Anne Daugherty Miles, 'Perspectives on the Senate Select Committee on Intelligence (SSCI) "Torture Report" and Enhanced Interrogation Techniques: In Brief' (2015). See also: (n 24).
[20] The approach taken by the US Administration is explained in Chapter Two together with the policy enabling medical professionals to become involved in the use of the EITs.

suggest that EITs should be distinguished from torture.[21] While it is not surprising that the administration which authorised the use of EITs would not want to concede that the practice was criminal, it is noteworthy that subsequent administrations have adopted the same position. The Obama Administration conceded that only 'in a limited number of cases, agency officers used interrogation techniques that had not been authorised, were abhorrent, and rightly should be repudiated by all. And we fell short when it came to holding some officers accountable for their mistakes.'[22] While this was a small positive step towards the formal recognition that torture has been used in some cases, the statement suggests that the use of torture was a result of some actors stepping outside of what was allowed by law and authorised by the US Administration, rather than recognising the state-authorised and systemic use of techniques that amounted to torture. Furthermore, the Obama Administration recognised that it failed to hold those few actors to account but did not propose how the issue could be rectified.

Despite the continuous challenge of the determination of torture by successive US administrations, there is already a very substantial body of literature that successfully rebuts its claims.[23] This thesis does not engage in that debate. The aim is rather to broaden the inquiry into other acts that are criminalised or unlawful under US domestic law, even if they do not meet the legal definition of torture.[24] For example, in the case of waterboarding, its designation as torture is seemingly

[21] Michael B. Mukasey, 'Opinion' *Wall Street Journal* (16 December 2014); Chuck Todd, Meet the Press: Cheney on the Senate Intelligence Report' *NBC News* (14 December 2014).
[22] John O. Brennan, 'Statement on SSCI Detention and Interrogation Program' (11 December 2014).
[23] Ruth Blakely, 'Dirty Hands, Clean Conscience? The CIA Inspector General's Investigation of "Enhanced Interrogation Techniques" in the War on Terror and the Torture Debate' (2011) 10 *Journal of Human Rights*; William O'Donohue, Cassandra Snipes, *et al.*, 'The Ethics of Enhanced Interrogations and Torture: A Reappraisal of the Argument' (2014) 24 *Ethics and Behavior* 109; Karen J. Greenberg, *The Torture Debate in America* (Cambridge University Press: Cambridge, 2006); Richard A. Posner, 'Torture, Terrorism, and Interrogation' in Sanford Levinson (rd.), *Torture: A Collection* (Oxford University Press: Oxford, 2004) 299.
[24] This topic has gained significant attention, for example: James R. Schlesinger, 'Final Report of the Independent Panel to Review DoD Detention Operations' (2004); Emma Harries, 'The CIA and Enhanced Interrogation Techniques in the War on Terror' (2017) 33 *Intelligence and National Security* 1; Thomas E. Ricks, 'I Don't Believe a Word of what Torture Advocates Say — And Neither Should You' *Foreign Policy* (27 July 2015); Amnesty International, 'USA: Human Dignity Denied: Torture and Accountability in the "War on Terror"' (2004); Centre for Constitutional Rights, 'Report on Torture, Cruel, Inhuman and Degrading Treatment of Prisoners at Guantanamo Bay, Cuba' (2006); Barry Gewen, 'The Gray Zone: Defining Torture' (2010) 173 *World Affairs* 49; Gregory Hooks and Clayton Mosher, 'Outrages Against Personal Dignity: Rationalising Abuse and Torture in the War on Terror' (2005) 83 *Social Forces* 1627; Michael Welch, 'Illusions in Truth Seeking: The Perils of Interrogation and Torture in the War on Terror' (2010) 37 *Social Justice* 123; Michele Chwastiak, 'Torture as Normal Work: The Bush Administration, the Central Intelligence Agency and "Enhanced Interrogation Techniques"' (2015) 22 *Organization: The Critical Journal of Organization, Theory and Society* 4; Mark

straightforward. However, in other cases, this may be more problematic, depending not only upon the mechanism of the chosen EIT, but also upon other factors, for example, how long the EIT was used for, how often and within what period, what other EITs were used in conjunction with it, and what the impact was upon the detainee's physical and mental state. This leads to the next point: that some treatment of detainees may amount to torture, even if this treatment was not a recognised EIT. For example, as will be elaborated on in Chapter Five, force-feeding or the withdrawal of medical care, although not recognised EITs, may amount to torture or other criminal or unlawful conduct. This thesis argues that it is important to move away from a framework that focuses on torture and to consider the different elements of these practices, including other criminal or unlawful acts. By disaggregating the elements of torture in this way, it might be possible to establish accountability for a broad range of activities undertaken by medical professionals in American detention centres, and especially where the EITs fall short of the legal definition of torture. A failure to establish all elements of the legal definition of torture should not be the end of the discussion. The discussion should continue and the door should be opened to consider a wider range of other criminal and civil wrongs and disciplinary offences.

Understandably, recognising EITs as torture may be beneficial, as torture has the benefit of an absolute (non-derogable) prohibition under international law standards, as reflected by US domestic law, a status that other criminal wrongs do not enjoy.[25] Furthermore, torture can be prosecuted in the

Danner, 'US Torture: Voices from the Black Sites' *The New York Review of Books* (New York, 9 April 2009); Tom Malinowski, 'Banned State Department Practices', in Kenneth Roth, Minky Worden and Amy D. Bernstein (eds.), *Torture: Does It make Us Safe? Is It Ever OK? A Human Rights Perspective* (The New Press: New York, 2005)139–44; Farnoosh Hashemian *et al*., 'Broken Laws, Broken Lives: Medical Evidence of Torture by the US Personnel and Its Impact' (Physicians for Human Rights, 2008).

[25] See: Article 2(2) of the UN CAT: 'No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.' Article 3 of the European Convention on Human Rights (ECHR): 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment.' Article 7 of the UN International Covenant on Civil and Political Rights (ICCPR): 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.' See also: Steven Greer, 'Is the Prohibition against Torture, Cruel, Inhuman and Degrading Treatment Really "Absolute" in International Human Rights Law?' (2015) 15 *Human Rights Law Review* 101; David Luban, *Torture, Power and Law* (Cambridge University Press: Cambridge, 2014) 6; Natasa Mavronicola, 'What is an "Absolute Right"? Deciphering Absoluteness in the Context of Article 3 of the European Convention on Human Rights' (2012) 12 *Human Rights Law Review* 723, 736; Joseph Raz, 'Hart on Moral Rights and Legal Duties' (1984) 4 *Oxford Journal of Legal Studies* 123, 131; Yuval Ginbar, *Why Not*

US even when it was committed abroad, for example, under the Alien Tort Statute.[26] Torture can also be prosecuted anywhere in the world based on the principle of universal jurisdiction.[27] Hence, where the act amounts to the legal definition of torture, it must be recognised accordingly. However, medical professionals are also subject to other laws prohibiting their involvement in various criminal conduct in general.[28] A clear determination of torture is not imperative. Where the acts of medical professionals do not meet the legal definition of torture, they should be further assessed against the legal definitions of battery, assault and other relevant criminal conduct and sanctioned as such. Before this thesis introduces a ten-stage taxonomy, which allows a clearer disaggregation of these different kinds of conduct, laying the foundations for a more nuanced, case by case analysis of what kind of sanction may be available, it discusses the available evidence.

3. Mapping the Available Evidence: Reports and Investigations

The four most relevant reports on the use of EITs for the case study of this thesis are the reports produced by the International Committee of the Red Cross, the Physicians for Human Rights, the Task Force, and the Senate Select Committee on Intelligence. The below section analyses the reports on what they can say regarding the involvement of medical professionals in EITs.

3.1. The ICRC Report on the Treatment of Fourteen 'High-Value Detainees' in CIA Custody

The International Committee of the Red Cross ('the ICRC'), an international humanitarian organisation whose 'mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance',[29] has reported on the situation in prisons and detention centres all over the world. Following reports of the use of torture in Guantanamo Bay, the ICRC requested

Torture Terrorists? Moral, Practical and Legal Aspects of the 'Ticking Bomb' Justification for Torture (Oxford University Press: Oxford, 2008) 320.

[26] See: Chapter Seven, Section 4.1.

[27] Cherif M. Bassiouni, 'Universal Jurisdiction for International Crimes: Historical Perspectives and Contemporary Practice' (2001) 42 *Virginia Journal of International Law* 81.

[28] For example, the crime of simple and aggravated assault/battery, recklessly endangering another person or criminal harassment. See: Chapter Five.

[29] International Committee of the Red Cross, 'Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody' (2007) 21. (Thereafter 'ICRC report')

that the US Administration allow it access to investigate the situation of detainees held there. The US Administration denied its requests and made numerous attempts to bar the ICRC from entering detention facilities used for the 'War on Terror.'[30] In September 2006, the ICRC was finally granted access to 14 so-called high-value detainees[31] ('HVD') transferred to Guantanamo Bay. It conducted private interviews with each detainee between October and December 2006.[32] The report surrounding these interviews was strictly confidential for several years and only the US Administration had access to its content before it was ultimately leaked into the public domain in 2009.

The report comments on the CIA detention programme, including the arrest and transfer of detainees, the conditions of detention and treatment in general, including the provision of basic medical care, and the role of medical professionals throughout the detention period.[33] It briefly remarks on the involvement of medical professionals in the ill-treatment of the 14 interviewed HVD,[34] finding that health personnel[35] were involved in a broad range of activities including both lawful and unlawful practices. For example, some of the interviewed HVD reported seeing medical professionals monitor their vital signs, including their oxygen saturation.[36] Mr Khaled Shaik Mohammed alleged that a medical professional was present during his interrogation which used one of the suffocation methods. The medical professional would stop the interrogators when the oxygen saturation fell too low.[37] The ICRC considered this involvement to be a lawful practice as it furthered the detainee's best interest by preventing hypoxia and associated consequences. This is an astonishing conclusion as it may ultimately accommodate medical involvement in torture. However, the alternative would have been

[30] 'War on Terror' is the ongoing international military campaign to counter international terrorism pronounced by the United Stated after 11 September 2001.
[31] 'High Value Detainee' is a term introduced by Bush Administration after 11 September 2001 to describe individuals believed to undertake an important role in or possess critical information of terrorist threats against the United States.
[32] ICRC Report (n 29) 3.
[33] ibid 3.
[34] Interviewed detainees: Abu Zubaydah, Ramzi Mohammed Binalshib, Abdelrahim Hussein Abdul Nashiri, Mustafha Ahmad AI Hawsawi, Khaled Shaik Mohammed, Majid Khan, Ali Abdul Aziz Mohammed, Walid Bin Attash, Mohammed Farik Bin Amin, Mohammed Nazir Bin Lep, Encep Nuraman (aka Hambali), Haned Hassan Ahmad Guleed, Ahmed Khalafan Ghailani, Mustafah Faraj Al-Azibi.
[35] Health personnel include here 'physicians, psychiatrists, psychologists, nurses and other para-health staff.' ibid.
[36] ICRC Report (n 29).
[37] ibid.

to leave the detainee without any medical assistance which would also be legally and ethically challenging.

The ICRC report recognises that some of the practices may have been unlawful. Among others, some of the HVD 'who were shackled in a stress standing position for prolonged periods' of time reported being monitored by medical professionals who would stop the method and recommend its continuation with adjustment.[38] One of the HVD, Mr Hambali, alleged that a medical professional would stop the use of the prolonged stress standing method being used upon him only when the detainee was willing to cooperate. According to his testimony, the medical professional who provided the monitoring, told him: 'I look after your body only because we need you for information.'[39] Another HVD told the ICRC that a medical professional threatened to withdraw his medical care unless he cooperated.[40] Furthermore, numerous HVDs reported to the ICRC that many of the medical professionals directly participated in the interrogations.[41]

The ICRC report approved of the medical professionals' involvement in so far as it aimed at providing medical care, thus having the detainee's best interests as the primary concern. The ICRC judged this behaviour to be consistent with the traditional role of medical professionals.[42] It also approved medical assessments to identify the detainee's medical needs[43] and the provision of fitness assessments before interrogations.[44] These conclusions are accepted here only as far as those activities are for the benefit of the detainee only and the information is protected from abuse by the interrogators. Similarly, the ICRC approved the medical professionals' provision of treatment to detainees who suffered from medical emergencies during interrogation.[45] It confirmed that the medical treatment of interrogation-inflicted injuries and other detention related symptoms was

[38] ibid 22.
[39] ibid.
[40] ibid.
[41] ibid.
[42] ibid 21.
[43] ibid 22.
[44] ibid.
[45] ibid.

necessary, and, based on the information available to them, it appeared to be of an appropriate standard.[46]

However, the ICRC report found that:

> in the case of the alleged participation of [medical professionals] in the detention and interrogation of the fourteen detainees, their primary purpose appears to have been to serve the interrogation process, and not the patient. In so doing the [medical professionals] have condoned and participated in ill-treatment.[47]

It further noted that, based on the evidence obtained, the medical professionals served the interrogators rather than the patient, which made them a party to the interrogation. This finding may call into question other activities medical professionals undertook in American detention centres, which otherwise might have been perceived as lawful (and in accordance with medical professional norms). The ICRC was critical of medical professionals for participating in any form of psychological or physical ill-treatment[48] and for using their scientific knowledge or skills to aid such practices.[49]

Based on the above examples taken from the ICRC report, the involvement of medical professionals may be grouped into four different roles (or four stages of involvement), namely, (1) 'performing medical checks before and after a transfer',[50] (2) treating the direct consequences of ill-treatment or other natural ailments resulting from prolonged detention,[51] (3) monitoring ill-treatment and (4) directly participating in interrogation.[52] The ICRC has noted that while two of the listed roles, namely, 'performing medical checks before and after transfer and treating' the direct consequences of ill-treatment or other natural ailments resulting from prolonged detention, were legally and ethically acceptable practices, the role of medical professionals in monitoring the ill-treatment and directly

[46] ibid.
[47] ibid.
[48] ibid.
[49] ibid.
[50] ibid 21.
[51] ibid.
[52] ibid.

participating in its administration was both unlawful and unethical.[53] Furthermore, the ICRC has found that the role of medical professionals monitoring interrogation was often more complex than that of a passive observer.[54] It found that the medical professional sometimes advised and gave instructions to the interrogators to stop, adjust and continue with the interrogation methods, and so moved from the role of a mere observer to that of a direct participant.[55]

The ICRC report is an important contribution that sheds light on the involvement of medical professionals in the interrogation of detainees, however, it has several limitations. First, it overwhelmingly relies on interviews with HVDs, the credibility of the information could be challenged as potentially self-serving. The ICRC found that the allegations detailed by HVD's appeared to be consistent even though each interview was conducted in isolation. Detainees were being held in incommunicado in solitary confinement before each interview.[56] Therefore, the HVD's were not able to verify their statements with one another before speaking with the ICRC interviewers.[57]

Furthermore, the information contained in the report is based on the information obtained during the interviews with the 14 HVD 'to the extent that each detainee agreed for it to be transmitted to the authorities.'[58] The ICRC does not clarify in its report whether they received information that was not approved by the detainees to be included in the report and disclosed. Therefore, it is unclear whether the report records the information obtained in its entirety. Considering that the HVDs remained in detention after the interviews, it is plausible that some information was not included in the report to prevent future reprisals. Consequently, it might be the case that some relevant information remained undisclosed.

[53] ibid.
[54] ibid.
[55] ibid 22.
[56] ibid 4.
[57] ibid 5.
[58] ibid 4.

While significant, the ICRC report presents certain challenges in the analysis of the involvement of the different types of medical professionals in American detention centres. Among others, it fails to distinguish between the involvement of ordinary medical professionals and Behavioural Science Consultants (BSCs).[59] This distinction is crucial. According to the US Administration, the two groups undertook different roles in American detention centres and had different duties towards the detainees.[60] However, this failure may be attributed to the fact that the ICRC report relies on interviews with the HVD's who would not be able to differentiate between the different groups of medical professionals involved in their interrogation. Alternatively, this may suggest that the distinction did not have any reflection in practice. Indeed, this thesis challenges the distinction by way of focusing on the relationship between medical professionals and detainees and duties that flow from such a relationship rather than the title of the medical professionals.

3.2. The Physicians for Human Rights Report

In June 2010, the Physicians for Human Rights ('PHR'), a non-profit organisation which uses the expertise of medical professionals to promote human rights and professional ethics in areas of medical concern,[61] published a report titled '*Experiments in Torture: Evidence of Human Subject Research and Experimentation in the Enhanced Interrogation Programme.*'[62] The report focuses predominantly on the issue of medical professionals' involvement in what the PHR classifies as experimentation on detainees. The PHR report is far more general and lacks the detail of the ICRC report. It was based primarily upon official documents available in the public domain, including the

[59] See US Department of Defence, 'Instruction 2310.08E, Medical Program Support for Detainee Operations' (6 June 2006). See also: Chapter Two, Section 4 for a detailed analysis.
[60] This is explained in Chapter Two.
[61] Physicians for Human Rights Website, available at http://physiciansforhumanrights.org/about/.
[62] Nathaniel Raymond *et al*, 'Experiments in Torture: Evidence of Human Subject Research and Experimentation in the "Enhanced" Interrogation Program' (Physicians for Human Rights, 2010). Thereafter 'PHR Report.' The PHR Report was authored by Nathaniel Raymond, Director of the Campaign Against Torture/Campaign for Accountability at Physicians for Human Rights (PHR), Scott Allen, MD, Co-Director of the Centre for Prisoner Health and Human Rights at Brown University and Medical Advisor to PHR, Vincent Iacopino, MD, PhD, PHR Senior Medical Advisor; Allen Keller, MD, Bellevue/NYU Program for Survivors of Torture, Stephen Soldz, PhD, President-elect of Psychologists for Social Responsibility and Director of the Centre for Research, Evaluation and Program Development at the Boston Graduate School of Psychoanalysis, Steven Reisner, PhD, PHR Advisor on Ethics and Psychology, and John Bradshaw, JD, PHR Chief Policy Officer and Director of PHR's Washington DC Office.

US Administration's memoranda on the treatment of the detainees.[63] The PHR correctly identifies the limitations of the sources used to produce their report in that numerous of the documents relied upon were heavily redacted and other associated documents remained classified at the time of preparing the report.[64] The PHR further identified that the true extent of the role of medical professionals in detention centres could not be adequately assessed because of the way the data was recorded. Furthermore, one of the allegations is that medical professionals did not record the abuse of the detainees or its signs.[65]

The PHR report found that medical professionals have played a significant role in the practice of the EITs.[66] It finds that the purpose of the presence of medical professionals during interrogation was primarily to collect and analyse data on the detainees' reactions to the EITs, constituting a form of human experimentation without consent.[67] For example, it notes that the medical professionals monitored and collected data of the detainees 'susceptibility' to severe pain[68] and the effects of sleep deprivation.[69] This then permitted tailoring of the EITs in accordance with the detainees' vulnerabilities.[70]

The PHR argues that the Office of Legal Counsel[71] ('OLC') 'appear to have accepted the unachievable assignment of designing torture-based interrogation techniques that were both "safe" and "effective."'[72] It alleges that while the aim to make the interrogation more effective was

[63] ibid 4.
[64] PHR Report (n 62) 4.
[65] See for example: Iacopino and Xenakis (n 19) 1.
[66] PHR Report (n 62) 6.
'1. It increased information on the physical and psychological impact of the CIA's application of the "enhanced" interrogation techniques, which previously had been limited mostly to data from experiments using US military volunteers under very limited, simulated conditions of torture.
2. It served to calibrate the level of pain experienced by detainees during interrogation, ostensibly to keep it from crossing the administration's legal threshold of what it claimed constituted torture.
3. It also served as an attempt to provide a basis for a legal defence against possible torture charges against those who carried out the interrogations, since medical monitoring would demonstrate, according to the Office of Legal Counsel memos, a lack of intent to cause harm to the subjects of interrogations.'
[67] Human experimentation means here researching EITs and their impact on detainees.
[68] ibid 6.
[69] ibid.
[70] ibid 4.
[71] Office of Legal Counsel is an office assisting the Attorney General in advising the President.
[72] PHR Report (n 62) 6.

attainable, the aim to make it simultaneously safer was impossible to achieve. The increase in effectiveness derives from an increase in pain and stress, which entails a decrease in safety.[73] Nonetheless, human experimentation was used to establish an artificial line distinguishing EITs from torture and to ensure that pain and both physical and mental harm were kept under 'control.'[74] As the PHR report demonstrates, medical professionals played a crucial role in ultimately certifying EITs, such as 'waterboarding, forced nudity, sleep deprivation, temperature extremes, stress positions, and prolonged isolation,' previously deemed as unlawful, as 'safe, legal, and effective.'[75] As such, medical professionals in American detention centres aimed to support the legal defence of the interrogators in any future legal actions.[76]

In its report, and contrary to the ICRC, the PHR oppose any involvement of medical professionals in EITs without exception. Although the degree of the involvement of medical professionals in Guantanamo Bay is still not fully known, the PHR classified any such activities as unlawful and unethical acts. Its findings were contrary to the ICRC which accepted some forms of medical assistance as lawful and ethical. This difference in approach may be linked to the nature of these bodies and their mandate. The ICRC's willingness to accept some practices as legal, although in very limited scenarios, is aimed at ensuring detainees have access to medical assistance in detention, which would align with the ICRC's foundational principles of humanity and neutrality.[77]

Contrary to the ICRC report, the PHR report is specifically focused on the involvement of medical professionals in EITs. It was the first report of this kind, presenting medical professionals as perpetrators playing a significant role and not as irrelevant complicitous actors. Despite lacking the detail of the ICRC report, the report was a trigger for further inquiries into the situation in American detention centres and medical involvement in EITs. The PHR report was prepared as a white paper

[73] It might be argued that achieving a way of causing pain that has no lasting physical health effects increased safety in comparison to another EIT that was less painful and more physically harmful. However, this would likely be outweighed by the long-term risk of psychological harm caused by the increased pain repeated over a longer period of time.
[74] ibid 6.
[75] ibid.
[76] ibid.
[77] ICRC, 'The Fundamental Principles of the International Red Cross and Red Crescent Movement' (2020).

calling upon the US Administration and the US Congress to fully investigate the situation in American detention centres post 9/11. It recommended that all actors involved in the use of EITs should be held accountable, calling upon the US Attorney General to open criminal investigations into the alleged crimes committed by medical professionals, the Office for Human Research Protections to investigate the alleged crimes committed by the CIA and other governmental actors, and the Department of Justice's Office of Professional Responsibility to investigate the alleged crimes committed by the OLC lawyers.[78]

3.3. The Task Force Report

In November 2013, a task force consisting of prominent medical professionals and lawyers[79] funded by the Institute on Medicine as a Profession and the Open Society Foundations produced a further report,[80] under the title, *'Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror.'*[81] The Task Force report was the first comprehensive study of medical professionals' involvement in the practice of capturing, detaining, interrogating, and treating individuals suspected of terrorism by the United States in the War on Terror.[82] As such, while partially relying on the findings of these two previous reports, its focus was far broader than events at Guantanamo Bay. The Task Force report discusses how medical involvement in EITs at American detention centres began, how it progressed and what legal changes contributed to its development. This analysis is significant in highlighting how deep-rooted medical involvement in EITs once was. Indeed, the Task Force

[78] PHR Report (n 62) 4.
[79] Scott A. Allen, MD, FACP University of California, Riverside, George J. Annas, JD, MPH Boston University, Karen Brudney, MD Columbia University, Richard N. Gottfried, JD New York State Assembly, Vincent Iacopino, MD, PhD Physicians for Human Rights, Allen S. Keller, MD New York University, Robert S. Lawrence, MD Johns Hopkins University, Steven H. Miles, MD University of Minnesota, Aryeh Neier Open Society Foundations, Deborah Alejandra Popowski, JD Harvard University, Steven Reisner, PhD Coalition for an Ethical Psychology, Hernán Reyes, MD, FMH Ob/Gyn International Committee of the Red Cross, David J. Rothman, PhD Columbia University, Leonard S. Rubenstein, JD Johns Hopkins University, Steven S. Sharfstein, MD, MPA Sheppard Pratt Health Systems, Albert J. Shimkus, Jr. U.S. Naval War College, Eric Stover University of California, Berkeley, Gerald E. Thomson, MD Columbia University, Frederick E. Turton, MD, MBA, MACP Emory University, Brig. Gen. (Ret.), Stephen N. Xenakis, MD, United States Army.
[80] In the report the term 'medical professionals' was used to include physicians, psychologists, and psychiatrists.
[81] Institute on Medicine as a Profession and OSF Joint Task Force Guantanamo Bay, 'Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror' (2013). Thereafter 'Task Force report.'
[82] ibid xi.

Report found that medical professionals' involvement in EITs was initially modest but quickly progressed, reaching the threshold of complicitous conduct and direct involvement in torture[83] through gradual policy changes. The below explores how the role of medical professionals progressed, while the policy changes are discussed in Chapter Two.

The Task Force found that medical professionals were primarily consulted to develop the EITs used in detention centres, without clarifying what such consultation involved. Their role then progressed to the supervision of EITs. Medical professionals with experience and expertise in 'Survival, Evasion, Resistance, and Escape' ('SERE') techniques[84] were utilised, they had the discretion and authority to stop interrogation to prevent the detainees from suffering severe harm.[85]

According to the report, a further significant step was made in 2002, when the US Department of Defence introduced the so-called Behavioural Science Consultation Team ('BSCTs', and members of the team called Behavioural Science Consultants, 'BSCs'). The BSCTs consisted of medical professionals who specialised in mental health.[86] The official aim of their presence in detention centres was to alter existing interrogation methods.[87] However, their involvement was more complex. According to the report, the BSCs assessed detainees' mental vulnerabilities and advised interrogators on how to use them for EITs. Although the vast majority of documents relating to the use of EITs in American detention centres remains classified, the Task Force found that there was sufficient evidence to support a claim that the BSCs recommended application of harsher EITs or their intensification during interrogation.[88] Even though the BSCs were already involved in assisting the CIA with developing and altering EITs, the CIA subsequently turned to James E. Mitchell, chief of psychology at the Air Force survival school, for professional assistance to further improve the EITs. The new and altered EITs were meant to 'create a state of learned helplessness and dependence

[83] ibid.
[84] ibid xi and 17.
[85] ibid xv.
[86] ibid.
[87] ibid xvii.
[88] ibid xviii and 20.

conducive to the collection of intelligence in a predictable, reliable, and sustainable manner.'[89] Finally, the Task Force found that many psychologists, who joined the BSCT, were actively involved in developing EITs that were approved and implemented in August 2002.[90]

The Task Force Report is the most comprehensive report to date of medical professionals' involvement in the interrogations of detainees in American detention centres. Its analysis helped to improve our understanding of the involvement of medical professionals in EITs, and how it progressed. Chapter Two shows that this gradual progression was more than a logical progression of duties, it was an intentional engagement by medical professionals to change the perception of EITs.

3.4. The Senate Select Committee on Intelligence Report

In December 2014, the Senate Select Committee on Intelligence ('SSCI') published a report on the CIA's EIT practices.[91] The SSCI is a committee established by the US Congress to oversee agencies of the federal government and provide information and recommendations to the executive and legislative branches. The SSCI report, as it exists in the public domain, is a mere 500-page summary of the full report of over 6,000 pages. The full report remains classified. The SSCI report is the most comprehensive review of the CIA Detention and Interrogation Program in general,[92] and it includes a thorough assessment of the effectiveness of the interrogation programme (before and after the introduction of EITs).[93] The SSCI report is primarily based on documents collected or provided by the CIA. In order to prepare it, the SSCI considered over six million pages of documents, which included 'CIA operational cables, reports, memoranda, intelligence products, and numerous interviews conducted of CIA personnel by various entities within the CIA, in particular the CIA's

[89] US Department of Justice Office of Legal Counsel, 'Background Paper on CIA's Combined Use of Interrogation Techniques' (2004) 1.
[90] ibid.
[91] Senate Select Committee on Intelligence, 'Committee Study of the Central Intelligence Agency's Detention and Interrogation Program' (3 December 2014) 9. Thereafter 'SSCI report.'
[92] ibid 9.
[93] ibid 9.

Office of Inspector General and the CIA's Oral History Program, as well as internal email and other communications',[94] all of which remain confidential or heavily redacted.

While it is clear that the authors of the SSCI report had access to resources that had never been made available before, the full SSCI report remains unpublished and the 500-page summary may have left out various details concerning the involvement of medical professionals. Also, the SSCI report focuses primarily on the CIA Detention and Interrogation Programme and not on the specific involvement of medical professionals in EITs, in contrast to the Task Force report. Furthermore, the 500-page summary of the SSCI report is itself heavily redacted. Many of its sources remain classified, as a result, it is not possible to cross-reference and review the sources. Nonetheless, the SSCI report is an important resource and, among its significant findings, the report successfully challenges two claims made by the US Administration: that the EITs helped to obtain crucial and reliable information from the detainees; and that they were safe, legal and effective.

If the SSCI report is published in full in the future, this may open the door to further investigation and legal and disciplinary proceedings against medical professionals for their involvement in EITs. This hope is substantiated by the fact that the 500-page summary of the SSCI report has already been used as the basis for a civil suit against two psychologists contracted by the CIA, James E. Mitchell and John Jessen. The suits were brought by former detainees Suleiman Abdullah Salim and Mohamed Ahmed Ben Sound, and by the estate of Gul Rahman, who died in custody.[95] The information contained within the SSCI report summary helped to not only substantiate their claims but also to dispense with the ever-present argument that such claims jeopardise national security. The information disclosed in the SSCI report has changed, and will likely continue to change, how similar civil claims are framed and the approach taken by courts to their resolution. Civil suits against the psychologists were assisted by the information declassified and presented in the SSCI report.

[94] ibid.
[95] SSCI Report (n 91) 9. See: *Salim* v *Mitchell*. See the discussion of the case in Chapter Seven.

Combined, these four reports provide an overview of the nature of medical involvement in EITs, however, they may also provide evidence that could be used as a basis for exploring new avenues of legal accountability. As the reports are superficial and selective in describing the involvement of medical professionals, this flows from the same issues of transparency and accessibility of the evidence, they should not be considered as being fully reflective of the situation in American detention centres and the contribution and responsibility of individual medical professionals. Nonetheless, the reports give a clear account of medical professionals who are involved in a wide range of activities which support the administration of EITs. Although it is clear from the reports that some cases of individual misconduct have occurred, at present there may not be enough credible evidence to initiate legal proceedings (whether disciplinary, civil or criminal). Nonetheless, as is clearly the case with the SSCI report, the information may help to identify the victims, or the medical professionals involved and assist with further inquiries necessary to build a case.

A further challenge to the evidence obtained in the reports, especially evidence obtained from former detainees, is that this evidence cannot be verified, for example, by checking against a detainee's medical records. The medical records that may exist are not currently available and would be made available only in exceptional circumstances. Also, based on the information contained in the reports, there is a high risk that the medical records are not comprehensive and do not include information on the use of EITs or any physical or psychological consequences of their use. This is because, as the reports suggest, medical professionals often failed to record their medical intervention adequately or at all.[96] Despite the limitations on resources, the aforementioned reports provide some empirical basis for at least initiating further investigations and evidence gathering.

As evidence of medical involvement in EITs continues to emerge, there is a compelling need for a more detailed account. To progress with this endeavour, in Section 4 below, this thesis proposes a

[96] See: Iacopino and Xenakis (n 19) 1.

ten-stage taxonomy that catalogues the different types of medical involvement in EITs. This taxonomy allows a more nuanced analysis of the issues than currently available.

3.5. The Literature on Medical Involvement in EITs

Apart from the four main reports described above, there exist numerous academic books and articles that comment on the situation in American detention centres, medical involvement and the laws applicable in such scenarios.[97] However, notably, the academic literature is based, and heavily relied upon, these reports and numerous official documents leaked into the public domain. Despite the aforementioned growing evidence of medical involvement in EITs, some aspects have not gained the attention which they deserve. The topic of the domestic and international law prohibiting torture is discussed in detail in the academic literature.[98] This literature focuses on the involvement of a broad range of actors, including CIA interrogators and US Administration lawyers. However, the issue of medical involvement in EITs has received far less attention. It is not that the involvement of medical professionals in EITs used in American detention centres is denied or suppressed. The fact of medical professionals' presence and contribution to the practice of EITs is often cited.[99] However, the primary focus of EIT-related inquires has been the actors who authorised the use of EITs and those most directly involved, such as CIA interrogators or their legal teams who justify their use.[100] As such, scholarship has tended to ignore medical professionals who are seen as being only complicitous

[97] For example, Steven H. Miles, *Oath Betrayed, Torture, Medical Complicity, and the War on Terror* (Random House: New York, 2006); Cohn (n 13).
[98] Hooks and Mosher (n 24); Ruth Blakeley and Sam W. Raphael, 'Governing Human Rights: Rendition, Secret Detention and Torture in the War on Terror' in Sophie Harman and David Williams (eds.), *Governing the World? The Practice of Global Governance* (Routledge: London, 2013); Karen J. Greenberg, *The Torture Debate in America* (Cambridge University Press: Cambridge, 2006); Rebecca Gordon, *Mainstreaming Torture: Ethical Approaches in the Post-9/11 United States* (Oxford University Press: Oxford, 2014); Jordan J. Paust, *Beyond the Law: The Bush Administration's Unlawful Responses in the "War" on Terror* (Cambridge University Press: Cambridge, 2007); Leila N. Sadat, 'Extraordinary Rendition, Torture, and Other Nightmares from the War on Terror' (2007) 75 *George Washington Law Review* 1200; Oren Gross, 'The Prohibition on Torture and the Limits of the Law' in Sanford Levinson (ed.), *Torture: A Collection* (Oxford University Press: Oxford, 2004); Mark J. Osiel, *The End of Reciprocity: Terror, Torture, and the Law of War* (Cambridge University Press: Cambridge, 2009).
[99] Michael Welch, 'American 'Painology' in the War on Terror: A Critique of "Scientific" Torture' (2009) 13 *Theoretical Criminology* 451; Myles Balfe, 'Why Did US Healthcare Professionals Become Involved in Torture During the War on Terror?' (2016) 13 *Journal of Bioethical Inquiry* 449; Abraham Halpern, John Halpern and Sean Doherty, 'Enhanced Interrogation of Detainees: Do Psychologists and Psychiatrists Participate?' (2008) 3 *Philosophy, Ethics, and Humanities in Medicine* 21.
[100] As discussed earlier in the chapter.

actors, who were acting at the request of the state.[101] The focus on those who authorised the EITs and upon the CIA interrogators who used them follows the tendency within international law to focus on senior figures and those most responsible for the crimes, while domestic law has a much broader focus on both the principal perpetrators and their accomplices.[102] However, a closer examination of the findings of the reports discussed above reveals that medical professionals' involvement in EITs was far more complex than is often assumed and that the doctors involved were not always merely following orders but took on a series of more active roles.[103] As medical professionals constituted an important element of the EIT machinery and enabled its functioning, their involvement should not be neglected.[104]

The most significant challenge faced by academic commentators engaged with the topic is that the evidence on medical involvement in EITs is often patchy. As discussed above, more evidence has come to light in recent years, however, this is not enough to build a case against any named individuals.[105] Rather than focusing on the evidence that would have to be gathered in each case, however, it is possible to explore ways in which medical professionals might be held accountable today with the information available at hand. This is the purpose of this thesis. Furthermore, it is hoped this work might inspire an attempt to uncover further evidence and to build cases against specific individuals.

A significant body of work on the topic of medical professionals' involvement in similar unlawful acts such as torture predate the use of EITs in the War on Terror. It is a significant focus on the

[101] Miles (n 97); Cohn (n 13); Gregg M. Bloche, 'Clinical Loyalties and the Social Purposes of Medicine' (1999) 281 *Journal of the American Medical Association* 268; British Medical Association, *BMA Medical Ethics Today: Its Practice and Philosophy* (BMJ Publishing Group: London, 1993); Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003).
[102] Roozbeh Baker, 'Customary International Law in the 21st Century: Old Challenges and New Debates' (2010) 21 The European Journal of International Law 190; Ilias Bantekas, 'The Contemporary Law of Superior Responsibility' (1999) 93 American Journal of International Law 573, 575–577; Ilias Bantekas and Susan Nash, *International Criminal Law* (Routledge-Cavendish: Oxford, 2007).
[103] See taxonomy in Section 4 below, and especially, stages seven, eight and ten.
[104] See Chapter Two.
[105] Nonetheless, see the case of *Salim* v *Mitchell* discussed in Chapter Seven.

conduct of Nazi doctors during World War II.[106] While this is an important body of work, there are significant differences between these cases and what has happened in the US; for example, legal and medical professional standards have developed significantly, and predominately, in response to the atrocities perpetrated by Nazi doctors. The research of Sigrid Mehring, an expert in international law, deals with a broad spectrum of issues relevant to the topic of the medical role during armed conflicts, the legal framework, and medical professional norms.[107] However, as her focus is not on the medical professionals in American detention centres, her analysis does not stand against the sophisticated justification of the type of EITs that medical professionals engage with in the US. This is discussed in Chapter Two. Indeed, there are several differences between the involvement of medical professionals in EITs that take place in American detention centres and other examples of medical involvement in criminal and unlawful acts. These differences do not only concern the degree of involvement in EITs but also the justification for their involvement. Furthermore, a comprehensive analysis of medical involvement in torture, pre-dating the War on Terror, was undertaken by the British Medical Association.[108] This includes a detailed study of legal and ethical standards, the different degrees of involvement, and proposals for setting up legal and ethical frameworks applicable at an international level.[109] The literature offers important guidance that may be applied to the case study of this thesis as it sets out the relevant legal and ethical professional standards that medical professionals knew or should have known they were bound by.

The vast majority of research on the subject of medical involvement in EITs engages with explaining the situation in American detention centres. It focuses on presenting the facts but offering little explanation of how medical professionals would be held accountable, or how the US Administration's arguments against such accountability might be discredited, namely, that medical professionals

[106] Robert J. Lifton, *The Nazi Doctors. Medical Killing and the Psychology of Genocide* (Basic Books, 2000) 384; Robert J. Lifton, 'Doctors and Torture' (2004) 351 New England Journal of Medicine 415.
[107] Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* (Brill Nijhoff: Leiden, 2014).
[108] British Medical Association, *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses* (Zed Books: London, 1998).
[109] ibid.

engaged in EITs lack a fiduciary relationship with their detainee patient, and that military duties override other medical responsibilities.[110]

While awareness of medical involvement has grown since the publication of the reports discussed above, there is a further failure: the tendency to focus on less severe forms of complicitous acts. For example, Michael Peel and Vincent Iacopino,[111] both medical professionals, predominately focus on less active stages of complicit conduct in relation to the crime of torture, for example, the failure to report or register signs of torture in medical records. As such, they focus on torture in isolation, namely, distinguished from other principal criminal offences. However, a failure to report is also a principal breach of a medical professional's duty. Consequently, by predominately focusing on complicity in torture, they neglect other breaches. Similarly, Chiara Lepora, a medical professional, and Joseph Millum, a bioethicist, fail to consider many of the participatory acts, and hence, their analysis cannot be accepted as a comprehensive analysis of the issues involved.[112] Indeed, the failure to address the broad spectrum of medical involvement in EITs results in erroneous conclusions being drawn, for example, that medical involvement in EITs is insignificant.[113]

Others, such as Gregg M. Bloche,[114] Michael A. Grodin and George J. Annas,[115] professors of law, and Gross[116] have focused on explaining the challenges experienced by medical professionals

[110] Leonard S. Rubenstein, 'First, Do No Harm: Health Professionals and Guantanamo Bay' (2007) 37 *Seton Hall Law Review* 733; Gretchen Borchelt, 'Break Them Down' (Physicians for Human Rights, 2005); Vincent Iacopino, Scott A. Allen and Allen S. Keller, 'Bad Science Used to Support Torture and Human Experimentation' (2011) 331 *New Series* 34; Leonard S. Rubenstein and George J. Annas, 'Medical Ethics at Guantanamo Bay Detention Centre and in the US Military: A Time for Reform' (2009) 374 *The Lancet* 353.

[111] Michael Peel and Vincent Iacopino, *The Medical Documentation of Torture* (Cambridge University Press: Cambridge, 2002).

[112] Chiara Lepora and Joseph Millum, 'Individual Complicity: The Tortured Patient' in Chiara Lepora and Robert E. Goodin (eds.), *On Complicity and Compromise* (Oxford University Press: Oxford, 2013).

[113] ibid. See also: William O'Donohue, Cassandra Snipes, Georgia Dalto, *et al*., 'The Ethics of Enhanced Interrogations and Torture: A Reappraisal of the Argument' (2014) 24 *Ethics and Behaviour* 109.

[114] Gregg M. Bloche and Jonathan H. Marks, 'Doctors and Interrogators at Guantanamo Bay' (2005) 352 The New England Journal of Medicine 6; Gregg M. Bloche and Jonathan H. Marks, 'When Doctors Go to War' (2005) 352 *The New England Journal of Medicine* 3.

[115] Michael A. Grodin and George J. Annas, 'Physicians and Torture: Lessons from the Nazi Doctors' (2007) 89 *International Review of the Red Cross Journal* 635; George J. Annas, 'Unspeakably Cruel - Torture, Medical Ethics, and the Law' (2005) 20 *New England Journal of Medicine* 2127; George J. Annas, 'American Vertigo: 'Dual Use,' Prison Physicians, Research, and Guantanamo' (2011) 43 *Case Western Reserve Journal of International Law* 631.

[116] Michael L. Gross, 'Bioethics and Armed Conflicts. Mapping the Moral Dilemmas of Medicine and War' (2004) 6 Hasting Centre Report 29, 34; Michael L. Gross, *Bioethics and Armed Conflicts. Moral Dilemmas of Medicine and War* (The MIT Press: London, 2003) 15,16.

working in American detention centres, including the difficult decisions they face in dual loyalty scenarios. However, they fail to consider that the different degrees of medical involvement in EITs require a more nuanced analysis and that even when facing dual loyalties, they cannot be justified in becoming involved in EITs that amount to torture or other criminal conduct.[117] Of these texts focused on medical involvement in EITs, the most comprehensive is written by Steven H. Miles.[118] Miles, a practising physician and professor of medicine, has written widely on the topic of medical involvement in torture, advocating that medical professionals must be held accountable for their involvement.[119] In his research on the issue, he summarises the systematic failings of the medical care system in detention centres[120] which were understaffed and inadequately equipped.[121] He collates and summarises the evidence of medical involvement available in the public domain and considers the legal and ethical issues concerned. He also categorises medical involvement in torture into interrogation, homicide, neglect, and silence. Miles defines homicide as causing death that was foreseeable and preventable, neglect as any failure to address the medical needs of detainees, and silence as failure to report the abuse.[122] Under interrogation, Miles includes all participatory and complicitous acts. Miles' categorisation goes beyond other accounts on the topic that predominately register medical assistance only. However, while his work is insightful and acknowledges a range of kinds of complicitous conduct, the four categories of interrogation, homicide, neglect, and silence are not nuanced enough to address the complexity of the situation and the broad range of acts involved. Moreover, there is some overlap between his four categories and gaps between them, such that acts that fall short of homicide are considered within the generic category of 'interrogation.' Yet, interrogation could also mean simple questioning and as such, assault and battery would fall within the category.

[117] This is discussed in Chapters Five and Six.
[118] Miles (n 97) 46.
[119] Steven H. Miles, *Torture Doctors: Human Rights Crimes and the Road to Justice* (Georgetown University Press: Washington DC, 2020).
[120] Steven H. Miles, 'Abu Ghraib: Its Legacy for Military Medicine' (2004) 364 *The Lancet Medical Journal* 725.
[121] ibid. Antonio Taguba, 'Taguba Report. Article 15-6 Investigation of the 800th Military Police Brigade' (2003); US Army Inspector General, 'Detainee Operations Investigation' (Department of the Army, 2004).
[122] Miles (n 97) 46.

Miles' analysis of medical involvement in EITs nonetheless offers a thought-provoking perspective on the topic. Contrary to the opinion of other authors, Miles argues that doctors in American detention centres were 'integral to both the design and the covering up and allowing the mistreatment of prisoners.'[123] Accordingly, they moved away from undertaking the role of safeguarding detainees and limiting the effects of torture upon them to preventing long-lasting harm to their health. As Miles correctly notes, '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.'[124] Accepting the role of medical professionals in this way means that it becomes more difficult to excuse their involvement: medical professionals are not simply silent observers, but active participants. Their importance to the practice of the EITs is discussed in Chapter Two. Miles further correctly notes that 'torturing societies create laws, policies, and regulations to authorise the practices. They establish, empower, and protect specialised practitioners and places.'[125] EITs have been designed in a way that prevents those involved from being held accountable. However, it is evident from the civil suit against two medical professionals who designed EITs, which was settled outside of court in August 2017, that this lack of accountability may be temporary.[126]

Apart from the aforementioned failure to consider the broad spectrum of involvement by medical professionals in American detention centres, the literature fails to consider the unique nature of the medical profession. Medical professionals have different legal and professional (ethical) obligations than the military or interrogators. This does not automatically mean that obligations would always conflict, especially in the case of criminal conduct.[127] As noted by Gross, this may be because the question of medical involvement in acts such as torture is often considered alongside whether

[123] Miles (n 97) 4.
[124] Steven J. Hoffman, 'Ending Medical Complicity in State-Sponsored Torture' (2011) 378 *The Lancet* 1535; OLC, Bradbury (n 4).
[125] ibid 4.
[126] See Chapter Seven, Section 4.1. discussion on *Salim* v *Mitchell*.
[127] Michael L. Gross, 'Doctors in the Decent Society: Medical Care, Torture and Ill-Treatment' (2004) 18 *Bioethics* 181.

participation in such unlawful acts could be justified.[128] Such an approach neglects the fact that any attempt to justify the use of torture is not an automatic justification of medical involvement in torture. One must respond to both questions to consider the position of medical professionals. This thesis argues that, in many cases, the key to this determination is whether medical professionals are in a fiduciary relationship with detainees and so subject to additional duties that other actors would not be obliged to adhere to. However, the existence of the fiduciary relationship is not always relevant as, for example, it is not relevant to liability for torture, which is always wrong regardless of whether a fiduciary relationship can be established. Chapters Five and Six engage with these questions.

In summary, the existing academic literature on liability towards detainees in American detention centres tends not to focus on medical professionals, and what literature there is on medical involvement tends to downplay their role, to focus on less severe forms of involvement. Even the most comprehensive account by Miles fails to offer a sufficiently nuanced framework for understanding medical involvement in American detention centres.[129] Further, none of this literature engages in-depth with the US Administration's attempted blanket exclusion of doctors' liability.

4. Taking a Systematic Approach to Medical Involvement in Enhanced Interrogation Techniques: The Taxonomy

Scrutinising the potential criminal conduct, civil wrongs or disciplinary offences of medical professionals involved in EITs requires a more structured approach rather than simply considering whether the acts amount to torture. The existing academic literature or reports do not offer such a taxonomy. The taxonomy introduced in this thesis portrays the range of medical involvement that requires attention. Cataloguing the different modes of involvement in EITs and presenting them in a form of taxonomy, would provide more clarity 1) in terms of the acts committed, and 2) when dealing

[128] Michael L. Gross, *Bioethics and Armed Conflicts. Moral Dilemmas of Medicine and War* (The MIT Press: London, 2003) 93.
[129] Steven H. Miles, *Torture Doctors: Human Rights Crimes and the Road to Justice* (Georgetown University Press: Washington DC, 2020); Miles (n 13); Borchelt (n 159); Rubenstein (n 110); Rubenstein and Xenakis (n 19); Chiara Lepora and Joseph Millum, 'The Tortured Patient: A Medical Dilemma' (2011) 41 *Hastings Centre Report* 38.

with questions of fiduciary relationship and the dual loyalties. This taxonomy is a useful guide to move beyond the analysis currently available and consider less severe degrees of involvement. The taxonomy engages with classifying involvement based on a range of characteristics such as the degree of involvement, whether an act or omission, whether it results in harm, whether harm is intended, whether it involves dishonesty, whether it breaches *prima facie* obligations, whether the doctor is acting as the principal or as an accomplice to someone else who is the primary actor, etc. The taxonomy pulls out the distinguishing features that have legal and ethical relevance. This exercise will ultimately encounter evidential difficulties, but it is important to have a clear analytical framework to inform discussion and investigation.

The taxonomy is designed around the concept of EITs, including conduct that may amount to torture, as well as other criminal or unlawful acts, or disciplinary offences. Furthermore, the taxonomy also includes acts that despite not being one of the official EITs can be considered akin to punishment. While evidence of medical involvement in detention centres is patchy, the four reports discussed above offer enough for a broad overview of the kinds of conduct in which doctors were involved. The below section distinguishes and categorises different stages of medical involvement in EITs based on the information in the four reports.

4.1. Stage One: Providing Basic Medical Care

The stage of providing basic medical care involves medical professionals assessing and providing medical assistance for detainees' medical needs. The cases from the four reports explored earlier in this chapter that fall under this category include medical professionals providing treatment for the detainees' illnesses, pre-existing conditions and interrogation-inflicted injuries, including actively intervening during prolonged interrogation to provide basic medical care for interrogation-inflicted injuries or in emergencies,[130] and ensuring a detainees' fitness for questioning.[131]

[130] ICRC Report (n 29).
[131] ibid 22. See also: PHR Report (n 62) 7; SSCI Report (n 140) 9; Task Force Report (n 81) 57, 203.

This stage involves medical care that is consensual, whether by way of an express consent when the detainee can give informed consent; where consent is implied from all the circumstances; or by way of implied consent in emergencies that render the detainees unable to provide consent.[132] The detainee (patient) being unconscious (emergencies) is the only instance when the provision of basic medical care could be provided without consent.[133] Following current law and medical professional standards, consent underpins the relationship between medical professionals and patients.[134] This is contrasted under stage nine on force-feeding of the detainees.

The provision of basic medical care resembles stage six of the taxonomy, although that refers to providing basic medical treatment to facilitate further interrogation (that may amount to criminal or unlawful conduct). This means that while both stages may involve the same medical treatment, the relevant *mens rea* to facilitate such acts will differentiate the two stages.

4.2. Stage Two: Monitoring the Use of Enhanced Interrogation Techniques

Stage two of the taxonomy involves medical professionals monitoring the detainees who are subject to EITs by third parties (whether the interrogators or other medical professionals). The ICRC report confirms that some medical professionals monitored interrogations to assess the effectiveness of EITs or to manage their risks.[135] One of the best examples is the case of Khaled Sheik Mohammed, discussed earlier in the chapter. According to Mohammed's statement to the ICRC, medical professionals were present during his waterboarding and monitored his oxygen saturation.[136] In his case, this monitoring was followed by a medical intervention (which could fall within the category of the provision of basic medical care discussed above). However, the reports discussed above also

[132] See for example: *Preston* v *Hubbell* (1948) 87 Cal. App. 2d 53, 57-58, *Wheeler* v *Barker* (1949) 92 Cal. App. 2d 776, 785.
[133] Where the detainee is unconscious, the consent would be assumed, unless there is evidence to suggest that the detainee did not allow such medical assistance.
[134] AMA, Code of Medical Ethics Opinion 2.1.1. See also: *Bouvia* v *Superior Court* (1986) 225 Cal. Rptr. 297; *Cobbs* v *Grant* (1972) 8 Cal. 3d. 229, 242.
[135] E.g. ICRC Report (n 29) 22; PHR Report (n 62) 7; SSCI Report (n 91) 9; Task Force Report (n 81) 57, 203; Miles (n 97) 66.
[136] ICRC Report (n 29) 21.

suggest that medical professionals would monitor the interrogations to obtain data which would then be used for tailoring the EITs to detainees' vulnerabilities.

This case illustrates the difficulty of separating the different stages of the taxonomy, which is nonetheless crucial since one kind of conduct may be legally and ethically permissible and the other may not. Here, the act of monitoring may significantly overlap with the provision of basic medical care, but while the former would likely constitute a lawful act, the latter (without further intervention) may not.

4.3. Stage Three: Developing New and Altering Existing Enhanced Interrogation Techniques

Medical professionals used their expertise to develop new or improve existing EITs.[137] They were consulted on the potential long-term consequences of EITs in general, altering them to maximise their effectiveness, and authorising them as 'legal, safe and effective.'[138] For example, Dr James E. Mitchell and Dr John Jessen, psychologists, designed EITs for the CIA,[139] and as such, are considered to be the architects of EITs.[140] Stage three is limited to cases of medical professionals designing new, or altering[141] the existing, EITs in general[142] and should be distinguished from the next stage, misusing detainees' medical data for EITs and stage seven of tailoring the EITs to individual detainees.

4.4. Stage Four: Misusing Detainees' Medical Data for Enhanced Interrogation Techniques

Medical professionals researched detainees' medical data to map their physical and psychological vulnerabilities and then shared detainees' confidential medical information with interrogators.[143] The

[137] PHR Report (n 62) 7-10, 19, 20; Task Force Report (n 81) xv, xvi, xvii-xx, 20-22; Helen McColl, Kamaldeep Bhui and Edgar Jones, 'The Role of Doctors in Investigation, Prevention and Treatment of Torture' (2012) 105 *Journal of the Royal Society of Medicine* 464; Miles (n 97) 66.
[138] OLC, Bradbury (n 4) 62.
[139] *Suleiman Abdullah Salim, et al.,* v *James E. Mitchell and John Jessen* (2018) Complaint, page 2, line 1. (Later cited as *Salim* v *Mitchell*).
[140] ibid page 7, line 7.
[141] Altering means here introducing changes to the existing EITs that aimed to increase the effectiveness of the EITs.
[142] PHR Report (n 62) 7-10, 19, 20; Task Force Report (n 130) xv, xvi, 20-22; McColl *et al.* (n 185) 464.
[143] PHR Report (n 62) 7-8.

misuse of data relates to medical data previously obtained by other medical professionals or newly obtained medical data for EITs.[144] 'Some provided information from medical records, clinical interviews, and medical examinations to interrogators for use in designing interrogation plans.'[145]

Stage four assistance equipped the CIA interrogators with personal and confidential medical information that played a crucial role in detainees' treatment,[146] with actual or constructive knowledge that this would be abused.[147] However, even if medical professionals did not know, or objectively could not have known, this would not change the fact that they may be misusing the medical data in breach of the duty of confidentiality, where they share such confidential information with third parties who do not have the right to receive it.

This stage is related to, but must be distinguished from, stage seven, which focuses on advising the interrogators on how to tailor the EITs to the vulnerabilities of each detainee. It involves the release of confidential medical information, while stage seven involves specific advice on how to use such information and adjust the EITs in accordance to the detainee's vulnerabilities to maximise the effects of the EITs.

4.5. Stage Five: Falsifying Evidence of the Use of Enhanced Interrogation Techniques

Stage five of the taxonomy includes falsifying evidence of the use of EITs by way of intentionally not recording their use or their effects upon the detainees, or intentionally recording false information. The evidence discussed in this chapter indicates that medical professionals failed to record injuries and signs of the EITs adequately or at all. It also confirms that medical professionals falsified death certificates to conceal the real cause of deaths.[148] This stage also includes concealing the abuse of

[144] Task Force Report (n 81) xviii.
[145] ICRC Report (n 29) 22; PHR Report (n 62) 7; SSCI Report (n 91) 9; Task Force Report (n 81) 57, 203; Miles (n 97) 66.
[146] ICRC Report (n 29) 22; PHR Report (n 62) 7; SSCI Report (n 91) 9; Task Force Report (n 81) 57, 203; Peter Slevin and Joe Stephens 'Detainees' Medical Files Shared: Guantanamo Interrogators' Access Criticised' *Washington Post* (10 June 2004).
[147] ICRC Report (n 29) 22; PHR Report (n 62) 7; SSCI Report (n 91) 9; Task Force Report (n 81) 57, 203; Lifton (n 106) 415-416.
[148] ibid 18-24; Miles (n 97) 24.

detainees through developing EITs that would not leave marks and therefore could not be discovered by way of medical examination.[149] The effect of such involvement is the concealment of evidence of the use of EITs and to mask the true extent of the injuries they cause (which in turn may amount to concealing evidence of a crime).

As producing incomplete medical notes is a pervasive problem visible in medical litigation more generally, to meet the threshold of this stage, the medical professionals would have to have the relevant *mens rea* to conceal the evidence (to enable the act of the principal or prevent his accountability). However, even if it does not meet the higher threshold that would come with intentional concealment, negligence is sanctioned here as well.

4.6. Stage Six: Treating Injuries to Facilitate Further Use of Enhanced Interrogation Techniques

Medical professionals are known to have treated detainees' injuries to enable further use of EITs (and so assist the principal's act of EITs).[150] This stage is very similar to stage one, providing basic medical care, however it differs in terms of 1) intent (*mens rea*), and 2) the duration of treatment (one-off treatment or regular care). First, the crucial consideration is whether the medical professional, when treating the detainees' injuries possesses the required *mens rea* to facilitate further EITs and so assist in the commission of the crime. Second, the nature of the treatment needs to be considered. Ordinarily, the type of treatment should not have any impact on the distinction. However, considering all the circumstances, the majority of cases falling under this stage would be cases where the professional has provided emergency treatment to EIT-inflicted injuries rather than pre-existing or other non-EIT related medical conditions. Ordinarily, the provision of medical treatment for injuries is legally and ethically sanctioned. This applies even to emergency treatment where medical professionals act to save the life or preserve the health of the injured person. However, in this scenario, medical

[149] PHR Report (n 62) 7-8.
[150] ICRC Report (n 29) 22.

professionals intend to facilitate EITs, so the ethics and legality of such assistance are questionable. One way may be to consider the existence of a motive, although, even without such motives, the *mens rea* can be established.[151] The distinction between the two stages may be clearer in cases where ordinary medical professionals were ordered to provide the necessary treatment to ensure that the detainee is ready for further interrogation. Such a clear order would help to establish the required *mens rea*.[152] However, it may not always be possible to evidence such an order. Other cases that would fall under stage six are cases where medical professional provide medical care without the detainee's valid consent.

4.7. Stage Seven: Advising on and Tailoring Enhanced Interrogation Techniques to a Detainee

Stage seven of the taxonomy involves medical professionals advising on and tailoring EITs to a specific detainee in order to improve the effectiveness of the EIT upon that specific detainee.[153] This stage incorporates:

> review[ing] medical information relevant to the conduct of interrogations, perform[ing] psychological assessment, recommend[ing] physically and psychologically coercive interrogation plans, monitor[ing] and provid[ing] feedback during interrogations, and [teaching] behavioural techniques to interrogators.[154]

The stage also includes medical professionals monitoring the detainees' medical conditions during interrogation, stopping them, and suggesting continuance with adjustments that would more effectively target the detainees' vulnerabilities.[155] Medical professionals would tailor EITs to

[151] Roman Veresha, 'Criminal and Legal Characteristics of Criminal Intent' (2017) 24 *Journal of Financial Crime* 121; Edward M. Dangel, *Criminal Law* (Edan Publications: Boston MA, 1951) 101.
[152] Unless it would be possible to argue that they acted under duress.
[153] ICRC Report (n 29) 21; PHR Report (n 62) 8.
[154] US Office of the Surgeon General Army, 'Final Report. Assessment of Detainee Medical Operations For OEF, GTMO, OIF' (2005); Miles (n 97) 54.
[155] ICRC Report (n 29) 22.

detainees relying on their medical expertise, the detainees' medical records, and observations in the course of interrogation.[156]

This stage of the taxonomy combines the elements of stage three, developing new and altering existing EITs (Section 4.3.), and stage four, misusing detainees' medical data for EITs (Section 4.4.) to establish the most effective EITs for a specific detainee. It differs as it is targeted and specific, not based on an abstract question on altering EITs or simple disclosure of confidential medical data. A medical professional could argue that, under stage three, the risk of injury to detainees is remote as the affected individuals cannot be easily identified.[157] Similarly, under stage four, despite misusing a detainee's medical data, it might prove difficult to establish whether and how the data will be used to further EITs.

One of the best examples to portray this stage is the case of a teenager, Mohamed Jawad, who the interrogators found anxious and distraught looking at a picture of his mother.[158] Ephron reports that:

> the psychologist recommended that Jawad be moved to a section of the prison where he would be the only Pashto speaker, and be moved again if he somehow began to socialise in his new block. The psychologist also suggested that interrogators emphasise to Jawad that his family appeared to have forgotten him: "Make him as uncomfortable as possible. Work him as hard as possible."[159]

Even though the recommendation did not specifically refer to the use of EITs *per se*, the recommended steps, which were calculated to act against Mohamed Jawad's psychological vulnerabilities, aimed to increase the level of his helplessness and ensure his cooperation.

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[156] Task Force Report (n 81) 27.
[157] See Chapter Four, Section 2.1.
[158] Stephen Soldz, 'Psychologists Defying Torture. The Challenge and the Path Ahead' in Adrienne Harris and Steven Botticelli (eds.), *First do no Harm: The Paradoxical Encounters of Psychoanalysis, Warmaking, and Resistance* (Routledge: New York, 2010) 73.
[159] ibid 73; Dan Ephron, 'The Biscuit Breaker: Psychologist Steven Reisner has Embarked on a Crusade to get his Colleagues out of the Business of Interrogations' *Newsweek* (27 October 2008).

4.8. Stage Eight: Force-Feeding

Stage eight of the taxonomy involves medical professionals prescribing and/or approving the force-feeding of detainees, assisting in the procedure, and controlling the detainees' vital signs during the procedure.[160] Medical professionals would prescribe force-feeding whenever the detainee's body weight dropped below 85 per cent of his ideal weight for reasons other than religious fasting.[161]

Force-feeding is not an EIT officially authorised by the US Administration. However, its practice in American detention centres, in general, or in specific cases, may amount to torture or a criminal offence, for example, assault or battery, civil wrong or a disciplinary offence.[162] For example, Eric Lewis, the attorney of one of the detainees, Abu Wa'el Dhiad, described his force-feeding as follows:

> He has been dragged out of his cell, trussed up like an animal, secured tightly to what the detainees universally called 'the torture chair,' had a 110-centimetre tube shoved up his nose, force-fed in the chair, then had the tube pulled out, forced from the chair to the ground and then carried back to his cell, put face down on a cement floor, the restraints removed with guards straddling his injured back.[163]

The practice of force-feeding is always controversial as it is conducted without the patient's consent and contrary to their wishes. However, in light of emerging evidence, it may be argued that, in American detention centres, force-feeding has reached a higher level of wrongdoing because it is accompanied by the use or threat of violence (in general or in certain cases) and the possibility that it could be used as a punishment (although this may be difficult to prove). It is unclear whether all cases

[160] ICRC Report (n 29) 22; PHR Report (n 62) 7; SSCI Report (n 91) 9; Task Force Report (n 81) 57, 203.
[161] ibid. See also: Institute on Medicine as a Profession and OSF Joint Task Force Guantanamo Bay, 'Medical Management of Detainees with Weight Loss' (2013).
[162] Mara Silver, 'Testing Cruzan: Prisoners and the Constitutional Question of Self-Starvation' (2005) 58 *Stanford Law Review* 631, 637–38. See also: *Thor* v *Superior Court* (1993) 855 P.2d 381.
[163] Carol Rosenberg 'US Attorney Defends Guantánamo Hunger Striker's Forced-Feedings' *Miami Herald* (6 October 2014).

of force-feeding are accompanied by the use or threat of violence or whether such cases are an exception.

4.9. Stage Nine: Withdrawing or Withholding Basic Medical Care from Detainees

Stage nine of the taxonomy involves medical professionals withdrawing or withholding basic medical care as a means of punishment[164] or until they cooperate with the interrogator.[165] For example, medical professionals in American detention centres denied antibiotics to treat detainees' injuries, for constipation, and prosthetic limbs as a part of the ill-treatment aiming to pressure them into cooperating.[166] Furthermore, in the case of Abu Wa'el Dhiab, an independent medical expert, Dr Sandra Crosby, testified that 'it look[ed] like medical care [was] being withheld' from Dhiab. She believed it was because of his disciplinary status.[167] Crosby also identified that the medical professionals in Guantanamo Bay had failed to examine the source of Dhiab's back problem, to treat it adequately to ease the symptoms, and to prevent their exacerbation.[168]

This stage focuses only on the act of intentional withdrawing or withholding of medical care (and not on any unintentional acts, for example, failure to assist due to a shortfall in resources). Stage nine involvement is not a recognised form of EIT and does not causally relate to the use of EITs. Nonetheless, this involvement may be considered and used as a form of punishment and inducement into cooperation.

4.10. Stage Ten: Directly Participating in Enhanced Interrogation Techniques

Stage ten of the taxonomy involves medical professionals directly participating in EITs. Even though the US Administration has claimed that medical professionals in American detention centres were

[164] ICRC Report (n 29) 22; PHR Report (n 62) 7; SSCI Report (n 91) 9; Task Force Report (n 81) 57, 203; Erik Saar and Viveca Novak, *Inside the Wire: A Military Intelligence Soldier's Eyewitness Account of Life at Guantanamo* (Penguin Press: New York, 2005) 73-74.
[165] *Al-Laithi Set al.* v *George Walker Bush et al*. (2005) Civ No 05VC429.
[166] ICRC Report (n 29) 22; PHR Report (n 62) 7; SSCI Report (n 91) 9; Task Force Report (n 81) 57, 203; Miles (n 13) 62, 131; *Al-Laithi Set al.* v *George Walker Bush et al*. (2005) Civ No 05VC429.
[167] Rosenberg (n 210).
[168] ibid.

not actively involved in EITs, the reports presented above prove otherwise, as between 20 and 50 per cent of the detainees have reported seeing medical professionals participating in the interrogations.[169] Also, as suggested in *Salim* v *Mitchell*, 'Jessen and Mitchell personally participated in the torture of Abu Zubaydah, including waterboarding.'[170]

5. The Primary or Secondary Liability for Involvement in Enhanced Interrogation Techniques

The above stages of involvement in EITs could fall within the purview of participating as a principal or as a secondary (complicitous) actor.[171] While the principal would be the person most responsible for the crime, under the doctrine of complicity, a secondary actor may be criminally responsible for an act committed by someone else by virtue of their assistance provided to the commission of the crime by the principal.[172]

For example, stages four, five and ten clearly involve primary liability, stage four being a breach of confidentiality, stage five being a fraud, stage ten being an act of torture, battery or assault, etc. However, stages four and five could also be classified as complicitous acts to the principal's act of the EIT. While assessing the primary liability of these acts can be established by considering the *mens rea* and *actus reus* of the offender, establishing secondary liability requires us to ask the question: 'Which of the activities that medical professionals undertake in American detention centres could amount to complicitous acts to the EITs?' Scholarly perspectives on the scope of complicity overwhelmingly support taking a broad approach to the issue. For example, Christopher Kutz, professor of law, correctly notes that any act can qualify for the purposes of recognising accomplice liability as 'virtually any kind of act, speech or otherwise, can satisfy the act requirement of accomplice liability, for virtually anything one person does can be a form of assistance or

[169] Taguba (n 121). S. Jordon, Sworn Testimony of 24 February 2004, Taguba Annex 54:48-53; J.C. Sivitis, Sworn Testimony of 14 January 2004, Taguba Annex 25/26.
[170] See: *Salim* v *Mitchell*.
[171] Sanford H. Kadish, 'Complicity, Cause and Blame: A Study in the Interpretation of Doctrine' (1985) 73 *California Law Review* 323; Jeremy Horder, *Ashworth's Principles* (Oxford University Press: Oxford, 2016) 433.
[172] Bryan A. Garner, *Black's Law Dictionary* (Thomson-West Publishing Company, 2004) 303. Richard G. Singer and John Q. La Fond, *Criminal Law (Examples and Explanations)* (Aspen Publishers: New York, 2001) 329.

encouragement to the other.'[173] Similarly, Joshua Dressler, professor of law, argues that the degree of assistance is immaterial.[174] Others, such as Wayne LaFave, professor of law, narrow the scope of what can fall within the purview of secondary liability although with a comprehensive list of qualifying acts such as 'aiding, abetting, advising, assisting, causing, commanding, counselling, encouraging, hiring, inducing, procuring'[175] that easily translate into legal language.

The legal provisions on complicity under the US law are covered in the Model Penal Code ('MPC'), a code that was introduced to reform and ensure consistency among the states' penal codes. Close to six decades after its introduction, approximately 3/4 of states have now recognised the MPC as their criminal code. The MPC makes a distinction between a direct perpetrator,[176] an indirect perpetrator[177] and an accomplice, taking a broad approach in defining the accomplice's involvement as soliciting in,[178] aiding, agreeing or attempting to aid in planning or committing the principal's crime.[179] While this broad approach to the issue of complicity allows for a wide range of complicitous actors, the question is whether it is feasible to recognise any degree of involvement or whether there should be a minimum threshold for triggering secondary liability. While such a threshold would provide a degree of legal certainty, Joachim Vogel, professor of sociology, correctly notes that 'a real problem is to define the *de minimis* (minimum threshold) of participation and responsibility.'[180] Indeed, the establishment of such a threshold may be artificial in that the perception of what constitutes *de minimis* would differ depending on the situation. James G. Stewart, associate professor of law, suggests that accomplice contribution has to be substantial as including all *de minimis* contribution

[173] Christopher Kutz, 'The Philosophical Foundations of Complicity Law' in John Deigh and David Dolinko (eds), *The Oxford Handbook of Philosophy of Criminal Law* (Oxford University Press: Oxford, 2011) 294. See also: James G. Stewart, 'Complicity' in Markus Dubber and Tatjana Hörnle (eds), *Oxford Criminal Law Handbook* (Oxford University Press: Oxford, 2014).
[174] Joshua Dressler, *Understanding Criminal Law* (Carolina Academic Press: Durham NC, 2018) §30.04(B).
[175] Wayne LaFave, *Substantive Criminal Law* (West's Criminal Practice Series, 2003) § 13.2.
[176] Section 2.06(1) of the MPC states that: 'A person is guilty of an offense if it is committed by his own conduct or by the conduct of another person for which he is legally accountable, or both.'
[177] Section 2.06(2)(a) of the MPC states that '(2) A person is legally accountable for the conduct of another person when: (a) acting with the kind of culpability that is sufficient for the commission of the offense, he causes an innocent or irresponsible person to engage in such conduct.'
[178] Sections 2.06(2)(c) & (3)(a)(i) MPC.
[179] Sections 2.06(2)(c) & (3)(a)(ii) MPC.
[180] Joachim Vogel, 'How to Determine Individual Criminal Responsibility in Systemic Contexts: Twelve Models' (2002) *Cashiers de Defense Sociale* 151, 160.

would be unfeasible.[181] Attaching a *de minimis* threshold would be difficult as even the smallest objective contribution may have a significant impact on the principal's conduct. While including all *de minimis* contribution may cause legal uncertainty, this inclusive approach may be better suited to cases where the act of the principal depends on the contributions made by many accomplices.

Similarly, the MPC recognises a broad range of complicitous acts without the need for the contribution to be substantial.[182] Indeed, Section 2.06 (3)(a)(ii) of the MPC prescribes that:

> A person is an accomplice of another person in the commission of an offence if: with the purpose of promoting or facilitating the commission of the offence, he aids or agrees or attempts to aid such other person in planning or committing it; or having a legal duty to prevent the commission of the offence, fails to make proper effort so to do.[183]

Following this approach, all of the stages of the taxonomy may be enough to trigger secondary liability and should be considered as such, in addition to stages where the acts amount to primary liability.

Finally, the question is whether there must be a causal link between the accomplice conduct and the act of the principal. For example, LaFave argues that '[t]he assistance given... need not contribute to the criminal result in the sense that but for it the [criminal] result would not have ensued.'[184] This follows a long-standing approach in the US jurisprudence derived from *Attorney General* v *Tally* where the court found:

> The assistance given, need not contribute to the criminal result in the sense that but for it the result would not have ensued… If the aid in homicide can be shown to have

[181] Stewart (n 173) 18. See also: Jane Stapleton, 'Perspectives on Causation' in Jeremy Horder (ed), *Oxford Essays in Jurisprudence* (Oxford University Press: Oxford, 2002) 67.
[182] Sections 2.06 (3)(a)(ii) of the MPC.
[183] ibid.
[184] LaFave (n 175) §13.2.

> put the deceased at a disadvantage, to have deprived him of a single chance of life which but for it he would have had, he who furnishes such aid is guilty, though it cannot be known or shown that the dead man, in the absence thereof, would have availed himself of that chance; as, where one counsels murder, he is guilty as an accessory before the fact, though it appears to be probable that murder would have been done without his counsel.[185]

Markus D. Dubber, professor of law and criminology, suggests that the MPC does not require a causal link as the drafters of the MPC 'measured individual culpability in terms of dangerousness',[186] namely, the act and intent of the accomplice. This means that the criminal law doctrine, as developed within the MPC, is engaged with identifying an individual projecting 'dangerousness' and this can transpire equally without a clear causal link to the principal's act. Dubber sets up the questions for the test of dangerousness as: 'Did the putative accomplice, through his soliciting or facilitating, reveal himself as the sort of person who requires penal intervention, for his own good as well as for the good of society at large?'[187] Chapter Seven argues that these are the type of questions that, for example, the state medical boards should ask when dealing with cases of medical professionals involved in the EITs and in assessing their fitness to practice medicine.

Nonetheless, some legal commentators assert that where assistance does not have any impact on the crime perpetrated by the accomplice, such assistance would not be culpable.[188] Sanford H. Kadish, criminal law scholar and theorist, claims that the deciding factor would be whether the assistance 'could have contributed to the criminal activities of the principal.'[189] The argument then states that in many cases, even without the accomplice's assistance, it is likely that the crime would still have

[185] *Attorney General* v *Tally* (1893) 15 So. 722, 738–39.
[186] Markus D. Dubber, 'Criminalising Complicity. A Comparative Analysis' (2007) 5 *Journal of International Criminal Justice* 4, 987.
[187] ibid.
[188] Kadish (n 171) 337.
[189] ibid 359.

transpired unchanged. However, this fails to recognise that any degree of assistance may help and encourage the principal to act further.

While this thesis does not engage with these questions, they are flagged here as they are important factors that would have to be taken into consideration when legal proceedings are contemplated against each medical professional. Further, they also show why it is important to consider the wide spectrum of conduct of medical professionals in EITs.

6. Conclusion

This chapter has outlined the extent of known medical involvement in EITs, demonstrating that medical professionals were important actors driving the machinery of EITs. This chapter began by setting out the empirical evidence of what occurred in American detention camps. The information on the topic is extremely limited and derives primarily from documents leaked into the public domain. Similarly, the information on medical professionals' involvement in EITs is poor and far from comprehensive. Numerous international institutions and civil society organisations have attempted to investigate the situation in American detention centres; however, they were not entirely successful in penetrating the shroud of secrecy that surrounds them. The four main reports discussed in this chapter are often too vague to establish a basis to support the necessary legal proceedings for individual actions. Indeed, and as it will be shown in Chapter Seven, the lack of sufficient and reliable information has been used by state medical bodies and courts to reject formal complaints about the conduct of medical professionals.

However, the partial release of the SSCI report has helped to fill some of the gaps in our knowledge. If the remaining part of the SSCI report were to be published, it may shed further light on medical professionals' involvement in EITs. In turn, the release of the full SSCI report may also help to address the issue of accountability. However, the recognition of EITs as torture continues to be challenged by the US Administration, which then impedes any legal actions for torture being taken against medical professionals. Nonetheless, even if the acts do not meet the threshold of torture, there

may still be scope for disciplinary, civil and criminal proceedings for other acts, for example, battery, unnecessary medical treatment, or breach of confidentiality. Currently, no medical professionals involved or complicit in EITs in American detention centres have been held accountable for their conduct,[190] whether by way of disciplinary, civil or criminal proceedings.[191] The alleged lack of a fiduciary relationship and overriding dual loyalties arguments have been central to the US Administration's attempt to block action taken against medical professionals to date. In the following chapters, this thesis explores how this could be challenged.

This chapter has also introduced a taxonomy of medical involvement that will constitute a basis for subsequent analysis in the following chapters. The taxonomy adds to our existing knowledge of medical involvement in EITs, building on the existing reports and categorising the different kinds of involvement. The taxonomy will be used in subsequent chapters to assist with the analysis of the different activities undertaken by medical professionals in American detention camps.

[190] David J. Nicholl, Trevor Jenkins, Steven H. Miles *et al*., 'Biko to Guantanamo: 30 years of medical involvement in torture' (2007) 370 *Lancet* 823.
[191] A civil suit brought against medical professionals who tailored the existing or developed new EITs (stage three of the taxonomy) or implemented EITs (stage ten) moved forward and settled out of court. See: *Salim* v *Mitchell*.

CHAPTER TWO: From Torture to Enhanced Interrogation Techniques: the US Administration's Justification of the Practice and Medical Involvement in it

1.Introduction

Chapter One reviewed the evidence that makes clear that medical professionals were involved in the use of EITs in American detention centres. As outlined in the ten-stage taxonomy, such involvement had many manifestations, including both complicit acts and direct participation in EITs. To accommodate their cooperation, under the auspices of the 'War on Terror', the US Administration introduced several policy changes that enabled and justified the use of EITs. A few of these policies specifically concerned medical professionals, demonstrating that the US Administration felt it necessary to involve them in the process.

The US Administration used various arguments to justify the use of EITs in detention centres. These arguments were highly contentious and they operated to normalise the use of torture. They have, however, been well explored and contested in the literature on the so-called 'War on Terror.' What has been less explored is the way in which the US Administration sought to redefine the medical duties of medical professionals in American detention centres to enable their involvement while hindering their legal accountability. This chapter explores these arguments, setting them in the context of wider US Administration's attempts to reduce the protections enjoyed by detainees. This chapter draws out two aspects of the US Administration's arguments that are of particular importance here: the fiduciary relationship and the dual loyalties.

This chapter, first, presents how the US Administration sought to strip detainees of their legal protections, including protections prohibiting acts such as torture, and the minimum standards of treatment afforded to detainees (Section 2). Second, it argues that the US Administration effectively normalised the use of torture, other criminal and non-criminal conduct such as EITs, with the presence of medical professionals in the camp an essential part of such normalisation (Section 3). Third, it argues that the US Administration redefined the medical duties of medical professionals in American

detention centres in order to deny the existence of a fiduciary relationship with detainees and to lay the basis for the claim that the doctors' duties as soldiers overrode any duties owed as medics towards the detainees (Section 4).

2. Stripping Detainees of Legal Protections

Many scholars, human rights advocates, politicians and international institutions consider that EITs amount to the legal definition of torture,[1] an act prohibited under international and US domestic law. While this thesis does not intend to challenge such a determination, it recognises that this may not always be the case and that individual examples of treatment would have to be judged against the legal definition of torture (and proving all elements of torture). This is not to support the analysis of the US Administration. Indeed, Chapter One argues that it is important to move away from a framework that focuses only on torture to the exclusion of other criminal and non-criminal conduct. Ultimately, by doing so, it aims to broaden the scope of the enquiry, while the US Administration's documents discussed in this chapter seek to narrow it.[2]

Some of the EITs, in certain situations, unavoidably meet the legal definition of torture, and because of the complete prohibition on torture, the US Administration had a difficult task to distance its EIT program from the definition of torture. This was particularly challenging as the EITs included such acts as walling 20–30 times consecutively,[3] abdominal slaps, dousing with water at 41 degrees

[1] See for example: Vincent Iacopino, Scott A. Allen and Allen S. Keller, 'Bad Science Used to Support Torture and Human Experimentation' (2011) 331 New Series 34, 35; Farnoosh Hashemian *et al*., 'Broken Laws, Broken Lives: Medical Evidence of Torture by the US Personnel and Its Impact' (Physicians for Human Rights, 2008); Nathaniel Raymond *et al*, 'Experiments in Torture: Evidence of Human Subject Research and Experimentation in the "Enhanced" Interrogation Program' (Physicians for Human Rights, 2010); Kenneth Roth, 'United States: Reports of Torture of Al-Qaeda Suspects' *Human Rights Watch News* (26 December 2002); Nils Melzer, 'Torture is Torture, and Waterboarding is not an Exception' *UN News* (30 January 2017).

[2] Including the US Administration's lawyers and the presidential opinion that provided an alternative interpretation of the US' international law obligations under the Geneva Conventions and the UN CAT.

[3] As explained by the Office of Legal Counsel, walling involves 'the use of a flexible, false wall. The individual is placed with his heels touching the flexible wall. The interrogator pulls the individual forward and then quickly and firmly pushes the individual into the wall. It is the individual's shoulder blades that hit the wall. During the motion, the head and neck are supported with a rolled hood or towel that provides a C-collar effect to help prevent whiplash.' US Department of Justice Office of Legal Counsel, 'Memorandum for John A. Rizzo, Interrogation of Al-Qaeda Operative' (1 August 2001). However, the detainee Zubaydah alleged that the interrogators slammed him against a concrete wall. See: Senate Select Committee on Intelligence, 'Committee Study of the Central Intelligence Agency's Detention and Interrogation Program' (3 December 2014) 9.

Fahrenheit (5 degrees Celsius) through a nozzle for up to 20 minutes, sleep deprivation for up to 180 hours in stress positions, and repeated waterboarding for up to 40 seconds at a time.[4]

The US Administration's approach to enabling and justifying the use of torture operated in three stages: namely, 1) stripping the detainees of any legal protections, 2) normalising torture by labelling it as EITs, and 3) redefining the duties of medical professionals in American detention centres. The focus of this section is on the main memoranda that set out the basis for stripping detainees of their legal protections; the 9 January 2002 memorandum written by John Yoo, who worked in the Office of Legal Counsel (OLC) at the US Department of Justice, the Presidential memorandum of 7 February 2002, and Assistant Attorney General Jay S. Bybee's memorandum of 1 August 2002.[5] The chosen memoranda are key, not only for explaining how detainees found themselves outside the scope of legal protections but also for justifying the engagement of medical professionals, with these two aims closely interrelated and interdependent. The following section begins by examining the most relevant arguments used in the documents and how they allowed the US Administration to enable treatment of the detainees that would ordinarily have fallen below the minimum standards laid out in domestic or international law.

2.1. Redefining the US' Obligations Under International Law

In a memorandum to William J. Haynes, General Counsel of the Department of Defence, John Yoo claimed that Al-Qaeda and Taliban detainees, and particularly those held in Guantanamo Bay, were not eligible for the 1949 Geneva Conventions' protections.[6] While this argument does not suggest that torture would have been permissible *per se*, it's clear aim is to strip detainees of the protections

[4] Institute on Medicine as a Profession and OSF Joint Task Force Guantanamo Bay, 'Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror' (2013) 20; Steven G. Bradbury, 'Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques that May be Used in the Interrogation of a High-Value al Qaeda Detainee: Memorandum to John A Rizzo' (2005) 7.

[5] There exists a number of other memorandums on torture (so-called 'Torture memos'). However, the three documents discussed in this chapters are key to the topic, namely, the memorandum of John Yoo of 9 January 2002, the Presidential memorandum of 7 February 2002, and Jay Bybee's memorandum of 1 August 2002.

[6] John C. Yoo, 'Memorandum to William J. Haynes, Application of Treaties and Laws to Al Qaeda and Taliban Detainees' (9 January 2002). Later cited as 'Yoo's Memorandum.'

which prohibit the use of torture under the Geneva Conventions.[7] This enabled the US Administration to make decisions which led to a treatment that fell below the standards required under the Geneva Conventions.[8] Yoo's Memorandum focused specifically on the treaties incorporated into the US law by virtue of the War Crimes Act ('WCA'),[9] including, the Geneva Conventions, international treaties that constitute the cornerstone of international humanitarian law, regulating the conduct of war and armed conflicts.[10] The four Conventions focus respectively on safeguarding sick and wounded soldiers on land and at sea, prisoners of war ('POWs'), and civilians. Yoo's Memorandum further considers any customary international law of armed conflicts that may otherwise apply.

The Geneva Conventions are relevant to detainees in American detention centres for two reasons. First, they prescribe who should benefit from the protections enshrined in the Geneva Conventions, including POWs and non-combatants.[11] Second, the Geneva Conventions affirm the prohibition of such criminal conduct as torture,[12] but also, among others, 'outrages upon personal dignity, in particular humiliating and degrading treatment.'[13] Hence, by following the Geneva Conventions, the US Administration could not have legally authorised the use of EITs that amounted to torture or other criminal conduct. Despite the Geneva Conventions' explicit message, setting clear standards for the treatment of POWs and non-combatants, Yoo's analysis of US obligations under international law towards al-Qaeda and Taliban detainees does not fully apply them.[14]

[7] But not under the UN CAT.
[8] ibid 6.
[9] War Crimes Act §2441 18 USC. The WCA is the US domestic legislation that directly incorporated several provisions of international treaties into the federal criminal code, including criminalization of grave breaches of the Geneva Conventions.
[10] Andrew Clapham, Paola Gaeta, Marco Sassòli, Iris van der Heijden (eds.), *The 1949 Geneva Conventions: A Commentary* (Oxford University Press: Oxford, 2015); Theodor Meron, 'The Geneva Conventions as Customary Law' (1987) 81 *American Journal of International Law* 348.
[11] Geneva Conventions include protections for POWs, for example, protection from being prosecuted for taking a direct part in hostilities, protections stating that they must be released and repatriated after the end of hostilities, must be treated humanely, protections against any act of violence and intimidation, a right to minimum conditions of detention (accommodation, food, clothing, hygiene and medical care).
[12] Geneva Convention I, Article 12; Geneva Convention II, Article 12; Geneva Convention III, Articles 13, 17 and 87; Geneva Convention IV, Articles 27 and 32; Geneva Convention I-IV common article 3, Articles 50, 51, 130 and 147 respectively; Additional Protocol I of 1977 (Article 75(2)(a)(ii)); and Additional Protocol II of 1977 (Article 4(2)(a)).
[13] Article 3 (1)(c).
[14] This is discussed later in the section.

As Yoo correctly identifies, the Geneva Conventions define relationships between states and not between states and non-state actors.[15] This line of reasoning is derived from the wording of Common Article 2[16] and is supported by jurisprudence.[17] It means that militia and terrorist groups would not be able to rely on the protections of the Geneva Conventions.[18] Nonetheless, Yoo recognises the existence of additional unique protection contained within Common Article 3 that goes beyond governing the relationship between member states and conflicts between them.[19] However, Yoo argues that Common Article 3 prescribes only minimum standards (as listed in the article), as opposed to adherence to the Geneva Convention as a whole.[20] Quoting Common Article 3 which focuses on 'armed conflict not of an international character', Yoo states that this means a civil war or 'a large-scale armed conflict between a state and an armed movement within its territory.'[21] Yoo relies on the text of the Geneva Conventions and the *travaux préparatoires* of the WCA incorporating Common Article 3 into the US law, suggesting that Congress did not intend the provisions to extend beyond civil wars.[22] Hence, he advises, it would not apply to the conflict between the US and the Taliban and/or Al-Qaeda.

Yoo asserts that since Al-Qaeda is a non-state actor and a non-signatory to the Geneva Conventions, its fighters and members engaged in hostilities of an international character are not eligible for the treaty protections incorporated by the WCA.[23] Therefore, Yoo argues that the nature of the conflict

[15] Yoo's Memorandum (n 6) 1.
[16] Common Article 2: 'In addition to the provisions which shall be implemented in peacetime, 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.'
[17] See: *Trans World Airlines, Inc* v *Franklin Mint Corp* (1984) 446 US 243, 253; *The Head Money Cases* (1884) 112 US 580, 598; *US ex rel. Saroop* v *Garcia* (1997) 109 F3d 165, 167.
[18] However, Article 1(4) of Additional Protocol covers also 'armed conflicts in which peoples are fighting against colonial domination and alien occupation and against racist regimes in the exercise of their right of self-determination.'
[19] Yoo's Memorandum (n 6) 6.
[20] ibid 1.
[21] ibid 6.
[22] Yoo's Memorandum (n 6) 7.
[23] ibid 11.

and the nature of the subjects in question preclude the application of the Geneva Conventions, including the fallback provisions of Common Article 3, thus denying protection to Al-Qaeda detainees. Common Article 3 itself does not protect POW other than through the general application of its principles. This analysis presented a hindrance to the application of international standards for detainees in American detention centres. This was the accepted interpretation until the US Supreme Court judgment in the case of *Hamdan* v *Rumsfeld*[24] which dealt directly with Common Article 3. [25]

The US Supreme Court in *Hamdan,* a case which established that detainees have the right of *habeas corpus* to challenge their detention, found that the US Court of Appeal and the US Administration were in the wrong to conclude that Common Article 3 did not apply to Hamdan 'because the conflict with Al-Qaeda, being "international in scope," does not qualify as a "conflict not of an international character."' The US Supreme Court clarified that 'the term conflict not of an international character' was used in contradistinction to a conflict between nations. The US Supreme Court continued that:

> Common Article 2 provides that "the [Geneva] 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." High Contracting Parties (signatories) also must abide by all terms of the Conventions *vis-à-vis* one another even if one party to the conflict is a non-signatory "Power," and must so abide *vis-à-vis* the non-signatory if "the latter accepts and applies" those terms. Common Article 3, by contrast, affords some minimal protection falling short of full protection under the Conventions, to individuals associated with neither a signatory nor even a non-signatory "Power" who are involved in a conflict "in the territory of" a signatory. The latter kind of conflict is distinguishable from the conflict described in Common Article 2 chiefly because it

[24] *Hamdan* v *Rumsfeld* (2006) 126 S. Ct. 2749.
[25] Frédéric Mégret, 'From "Savages" to "Unlawful Combatants": A Postcolonial Look at International Humanitarian Law's "Other" in Anne Orford (ed.), *International Law and Its Others* (Cambridge University Press: Cambridge, 2006); Frédéric Mégret, 'Detention by Non-State Armed Groups in Non-International Armed Conflicts: International Humanitarian Law, International Human Rights Law and the Question of Right Authority' in Ezequiel Heffes, Marcos D. Kotlik and Manuel Ventura (eds.), *International Humanitarian Law and Non-State Actors: Debates, Law and Practice* (Springer, 2020).

> does not involve a clash between nations (whether signatories or not). In context, then, the phrase "not of an international character" bears its literal meaning.'[26]

In his memorandum, Yoo further re-defines US obligations towards detainees narrowing the applicability of the Geneva Conventions. While Yoo recognises that no member state is permitted to absolve itself from liability for grave breaches of the Conventions, he claims that the WCA does not criminalise such violations. Yoo argues that:

> only by causing great suffering or serious bodily injury to [prisoners of war], killing or torturing them, depriving them of access to a fair trial, or forcing them to serve in the Armed Forces, could the US commit a grave breach.[27]

Yoo's statement does three things. First, Yoo separates 'causing great suffering or serious bodily injury' and torture, to establish that not all suffering or serious bodily injury would reach the threshold of torture. While it is accepted that inflicting pain or suffering does not on its own amount to torture, the additional elements required are typically said to turn on the existence of other particulars (both *mens rea* and *actus reus*)[28] and not the level of pain or suffering involved itself.[29] Yoo notes that, in general, causing some pain or suffering may be lawful. And indeed, inflicting a degree of pain and suffering may accompany lawful sanctions. However, this is significantly different from intentionally inflicting pain or suffering to obtain information or to punish. A further point is vital here: Yoo's reference to the level of pain or suffering lays the foundation for the argument that medical professionals' assistance was required in the camps, as only they would be qualified to determine the level of pain experienced by detainees. Second, the apparent reference to POWs in this statement is deliberate, laying the groundwork for a subsequent argument: that while POWs are covered by

[26] *Hamdan* v *Rumsfeld* (2006) 126 S. Ct. 2749, 67.
[27] ibid 6.
[28] David Luban and Henry Shue, 'Mental Torture: A Critique of Erasures in U.S. Law' (2011) 100 *Georgetown Law Journal* 24 ff. See also: Kate Riggs, Richard Blakely, and Jasmine Marwaha, 'Prolonged Mental Harm: The Torturous Reasoning Behind a New Standard for Psychological Abuse' (2007) 20 *Harvard Human Rights Journal* 263.
[29] However, this argument is subsequently used and elaborated upon by Flanigan when he explains what levels of pain and suffering are required for torture providing an interpretation that goes against the ordinary reading of the provision.

international legal protections, detainees in American detention centres, not falling within the ambit of the definition, are not. Third, the reference to a grave breach is of significance. Article 50 of the Geneva Convention I states that '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*.'[30] As such, the question of the status of detainees matters. If any of the acts identified in Article 50 are committed against persons not covered by the Convention, a grave breach would not have been committed.

Dealing with the applicability of the international customary law, Yoo suggests that while international customary law does not bind the US President, 'the President may wish to extend some or all of such laws to the conduct of the United States military operations in this conflict.'[31] Yoo's analysis also fails to consider that the US international law obligations concerning the prohibition of torture (and other forms of criminal conduct) are broader than those contained in the Geneva Conventions, including under the UN CAT and the UN International Covenant on Civil and Political Rights.[32]

2.2. Determining the Detainees as Ineligible for International Law Protections

Aside from commenting on the applicability of the Geneva Conventions to the conflict, Yoo analyses the status of the members of Al-Qaeda and the Taliban under the Geneva Convention. He claims that Al-Qaeda would not qualify as POWs for the purposes of Article 4 of the Third Convention as it only applies in those circumstances where Articles 2 and 3 apply.[33] Also, apart from circumstances where Common Articles 2 and 3 apply, Article 4 sets out the conditions for POW status, with an additional

[30] [Emphasis added].

[31] Yoo's Memorandum (n 6) 41. Over the subsequent years, Obama Administration clarified its position on the applicability of the UN CAT to such situations claiming that 'a time of war does not suspend the operation of the [UN CAT], which continues to apply even when a State is engaged in armed conflict. Although the more specialised laws of war—which contain parallel categorical bans on torture and other inhumane treatment in situations of armed conflict—take precedence over the [UN CAT] where the two conflict, the laws of war do not generally displace the [UN CAT]'s application.' See: The White House, Office of the Press Secretary, Statement by NSC Spokesperson Bernadette Meehan on the US Presentation to the Committee Against Torture, 12 November 2014.

[32] Alberto R. Gonzales, Responses to Written Questions of Senator Richard J. Durbin.

[33] Yoo's Memorandum (n 6) 13.

set of requirements from the Hague Convention IV, namely, being commanded by 'responsible individuals, wearing insignia, carrying arms openly, and obeying the laws of war.'[34] On this analysis, any terrorist group would highly likely fall short of recognition for the sake of protection.[35] Consequently, according to Yoo, Al-Qaeda members could not qualify as POWs as their treatment is not subject to any treaty provisions.[36]

Yoo's analysis of the applicability of the Geneva Conventions provisions to the Taliban results in a similar conclusion. However, here, he fails to recognise that the application of the treaty protections should be automatic. Yoo notes that Afghanistan was a state party to the conventions but denies their applicability in the case, claiming that at the time Afghanistan was a 'failed state' governed by a militia or faction and not a fully functioning government.[37] As such, he suggests that, during the period in question, Afghanistan did not have the necessary 'attributes of statehood' to be considered a party to the relevant conventions and receive its privileges and protections.[38] He claims that the ruling Taliban was dominated by Al-Qaeda to the degree that it was not possible to distinguish and separate them.[39] Hence, on Yoo's analysis, the Taliban militia is stripped of the protections of the Geneva Conventions. He also alleges that it was for the US President to decide whether Afghanistan ceased to be a state[40] and the question of whether a state was able to perform its treaty obligations was political.[41] Yoo suggests that Afghanistan was in a condition of statelessness and was therefore unable to continue to be a member of the relevant conventions.[42]

Subsequently, Jay S. Bybee, Assistant Attorney General for the OLC, produced a memorandum to William J. Haynes, General Counsel of the Department of Defence, with his final opinion on the

[34] ibid. See: Article 1 of the Hague Convention IV.
[35] However, the situation may be different in relation to such terror groups like Daesh, because of their organisation with a clear chain of command, wearing insignia (but not following laws of war).
[36] Yoo's Memorandum (n 6) 6.
[37] ibid.
[38] ibid.
[39] ibid.
[40] ibid 14.
[41] See: The Executive's constitutional authority to decide 'political question' in *Terlinden* v *Ames* (1902) 184 US 270, 288 and *Clark* v *Allen* (1947) 331 US 503.
[42] Yoo's Memorandum (n 6) 17.

application of treaties and laws to Al-Qaeda and the Taliban.[43] Bybee's memorandum was substantially based on Yoo's opinion from 9 January 2002, claiming that the treaties did not protect Al-Qaeda members since they were non-state actors and that the President had sufficient grounds to find that the Taliban militia was similarly not protected. While the focus of the memorandum was to determine the applicability of laws and treaties to Al-Qaeda and the Taliban militias and so the affirmative obligations towards these groups, the underlying message is that this was the first step towards ultimate normalising the use of torture on Al-Qaeda and Taliban detainees by rebutting the presumption they benefited from any international legal protections which set out minimum treatment standards.

Yoo's analysis has faced a significant amount of criticism,[44] from civil society representatives (for example, human rights non-governmental organisations[45]), academics and courts,[46] but also from individuals within the US Administration, including the US Department of Defence's Deputy Secretary of Defence William Taft.[47] His claims have also been convincingly rebuked by legal scholars who confirm that the laws of war applied to the conflict between the US and Afghanistan[48] regardless of whether it was an international or non-international armed conflict.[49] According to

[43] Jay S. Bybee, 'Memorandum to William J. Haynes, Re: Application of Treaties and Laws to Al Qaeda and Taliban Detainees' (22 January 2002) 1. Thereafter 'Bybee's Memorandum.'
[44] Bradley W. Wendel, 'The Torture Memos and the Demands of Legality' (2009) 12 *Legal Ethics* 107; Nancy V. Baker, 'The Law: Who Was John Yoo's Client? The Torture Memos and Professional Misconduct' (2010) 40 *Presidential Studies Quarterly* 750; Milan Markovic, 'Can Lawyers Be War Criminals?' (2007) 20 *The Georgetown Journal of Legal Ethics* 347; James Ross, 'Black Letter Abuse: The US Legal Response to Torture Since 9/11' (2007) 89 *International Review of the Red Cross* 867.
[45] Roth (n 1); International Helsinki Federation for Human Rights, 'Anti-terrorism Measures, Security and Human Rights: Developments in Europe, Central Asia and North America in the Aftermath of September 11' (2003); Amnesty International 'Report 2003 – United States of America' (2003); Amnesty International, 'Unlawful Detention of Six Men from Bosnia-Herzegovina in Guantánamo Bay' (2003); International Committee of the Red Cross, United States: ICRC President urges progress on detention-related issues' *ICRC News* (16 January 2004); Dick Marty, 'Alleged Secret Detentions and Unlawful Inter-state Transfers of Detainees Involving Council of Europe Member States' (2006). See also: *Al Nashiri* v *Poland* (2014) ECHR 231, 502, 503, 516.
[46] See for example: Fionnuala Ní Aoláin, 'Hamdan and Common Article 3: Did the Supreme Court Get It Right?' (2007) 91 *Minnesota Law Review* 1522; Cass R. Sunstein, 'Clear Statement Principles and National Security: Hamdan and Beyond' (2006) *The Supreme Court Review* 1.
[47] William Taft IV, 'Memorandum to John Yoo, Re: Yoo Draft Memorandum of January 9, 2002' (11 January 2002).
[48] See for example, Jordan J. Paust, *Beyond the Law: The Bush Administration's Unlawful Responses in the "War" on Terror* (Cambridge University Press: Cambridge, 2007) 2; Annyssa Bellal, Gilles Giacca, and Stuart Casey-Maslen, 'International law and armed non-state actors in Afghanistan' (2011) 93 *International Review of the Red Cross* 47; Marco Sassoli, 'Use and Abuse of the Laws of War in the War on Terrorism' (2004) 22 *Law and Inequality: A Journal of Theory and Practice* 195.
[49] Joan Fitzpatrick, 'Sovereignty, Territoriality, and the Rule of Law' (2002) 25 *Hastings International and Comparative Law Review* 306.

David Weissbrodt and Amy Bergquist, professor of law and attorney respectively, this includes Al-Qaeda, a non-state actor, to the extent that the conflict with Al-Qaeda was part of the conflict between the US and Afghanistan,[50] an argument flowing from the jurisprudence in *Hamdan* v *Rumsfeld*.[51]

Even though Yoo's memorandum confirms that the use of torture would constitute a grave breach of the Geneva Conventions, his narrow interpretation of the scope of the provisions regarding the subjects' eligibility precludes triggering the protections within them. As a result, he provided legal analysis to accommodate a different treatment of Al-Qaeda and Taliban detainees as falling outside the Geneva Conventions' protections (and the equivalent in US domestic law).

2.3. Establishing the New Category of Unlawful War Combatants

Yoo's analysis created a gap in the interpretation of the US' international law obligations suggesting that non-state actors such as the Taliban or Al-Qaeda were occupying a space outside of international law provisions such as the Geneva Conventions, an interpretation that international law does not recognise.[52] To address this matter, on 7 February 2002, George W. Bush issued a memorandum to the Vice President, the Secretary of State, and the Secretary of Defence, settling the issue on the applicability of the Geneva Conventions in the conflict. In the memorandum, President Bush suggests that new thinking in the law of war and armed conflicts was required to meet the needs of the new threat, as manifested by the 9/11 attack, albeit that thinking must be consistent with the principles of the Geneva Conventions.[53]

In his memorandum, Bush replicates the claim that none of the Geneva Conventions applied to the conflict with Al-Qaeda since they were not a party to the Geneva Conventions, in line with the

[50] David Weissbrodt and Amy Bergquist, 'Extraordinary Rendition and the Humanitarian Law of War and Occupation' (2007) 47 *Virginia Journal of International Law* 295, 303.
[51] See *Hamdan* v *Rumsfeld* (2006) 126 S. Ct. 2749, 2795.
[52] See: Articles 43 and 50(1) of the First Protocol; Article 4 (A) (1) and (2) of the Third Geneva Convention. See also: Yves Sandoz, Christophe Swinarski and Bruno Zimmermann, *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949* (International Committee of the Red Cross: Geneva, 1987) 610.
[53] George W. Bush, 'Memorandum to Vice President, Secretary of State, Secretary of Defence, *et.al*., Re: Humane Treatment of al Qaeda and Taliban Detainees' (7 February 2002) 1. Thereafter 'George W. Bush's Memorandum.'

opinions of Yoo and Bybee. However, contrary to Yoo, Bush confirms that the Geneva Conventions applied to the conflict with the Taliban. In line with Yoo's arguments, Bush alleged that Common Article 3 did not apply to the conflict with Al-Qaeda or the Taliban as per the international character of the conflict. However, contrary to Yoo, Bush claims that the reason Taliban detainees did not qualify for the protection of Article 4 of Geneva Convention was that they were not POWs but 'unlawful combatants' of war, a new category not otherwise existing under international law.[54] This new category for subjects of unlawful war combatants is not reflected in international legal provisions, and hence their status and protections are, arguably, neither defined nor guaranteed. This allowed for the US Administration to argue that international law did not apply to them.[55] As such, it neglects the possible far-reaching consequences of such a move. Indeed, as Jordan J. Paust, professor of law and former Judge Advocate General Officer of the US Army, notes it could have 'dangerous consequences with respect to permissible forms of non-state actor violence, application of the laws of war in actual armed conflicts, and protections of members of the armed forces of the United States and other states.'[56] Similarly, it neglected the US military's arguments that adherence to the laws of war was in the US interest.[57] Nonetheless, Bush confirms that all detainees were to be treated humanely and to 'the extent appropriate and consistent with military necessity, in a manner compatible with the principles of Geneva.'[58] This may further suggest that military necessity trumps the Conventions, namely, that humane treatment could be suspended for military necessity.[59] Despite

[54] Oona A Hathaway, Paul K Strauch, Beatrice A Walton *et al*, 'What Is a War Crime' (2019) 44 *Yale Journal of International Law* 53, 111.
[55] See: George W. Bush's Memorandum (n 53).
[56] Jordan J. Paust, 'War and Enemy Status after 9/11: Attacks on the Laws of War' (2003) 28 *Yale Journal of International Law* 325, 326.
[57] Judge Advocate General's School, Department of Army, Operational Law Handbook (2010) 10. Subsequently, in 2006, the category of unlawful combatants was introduced into the US domestic law, the US Military Commissions Act of 2006, that defines the unlawful enemy combatant as 'a person who has engaged in hostilities or who has purposefully and materially supported hostilities... who is not a lawful enemy combatant' or 'a person who, before, on, or after the date of the enactment of the [MCA of 2006], has been determined to be an unlawful enemy combatant by a Combatant Status Review Tribunal or another competent tribunal.' 10 U.S.C. § 948a (1) (2006). See also: Alexander Fraser, 'For the Sake of Consistency: Distinguishing Combatant Terrorists from Non-Combatant Terrorists in Modern Warfare' (2017) 51 *University of Richmond Law Review* 593; Jeffrey F. Addicott, 'Rightly Dividing the Domestic Jihadist from the Enemy Combatant in the "War Against Al-Qaeda" - Why it Matters in Rendition and Targeted Killings' (2012) 45 *Case Western Reserve Journal of International Law* 259.
[58] ibid.
[59] Derek Jinks and David Sloss, 'Is the President Bound by the Geneva Conventions' (2004) 90 *Cornell Law Review* 97.

Bush's vaguely worded direction that detainees should be treated 'humanely', they were stripped of any protections that may have been left after Yoo's and Bybee's analyses.

3. Normalising the Use of Torture as Enhanced Interrogation Techniques

The memoranda discussed above narrowed and excluded international and domestic law protections relating to torture and enabled treatment that fell short of the legally prescribed minimum standard. However, the main contribution to normalising the use of torture as the EITs, which ultimately led to engaging the medical professionals, was Bybee's analysis of the applicability of the US domestic law prohibition of torture found in section 2340A of the 18 United States Code. Following Yoo's assertion that not every degree of pain or suffering will be enough to meet the threshold of torture, Bybee now redefined how the provisions on torture should be interpreted and applied.[60] On this basis, he argued that EITs could not constitute torture.

Bybee claims that 'Section 2340A must be construed as not applying to interrogations undertaken, according to his Commander-in-Chief authority.'[61] This argument mirrors Yoo's claim that Congress cannot place limitations on the President's anti-terrorism policy, even if it includes such practices as torture. However, it goes even further to suggest that the prohibition of torture does not apply to interrogations authorised by the US President.[62] Bybee asserts that even if, ordinarily, the interrogation methods would have been in breach of Section 2340A, this would not have been the case where such interrogation is authorised by the US President. According to this interpretation, as the US President is deemed to have complete authority over the conduct of the War on Terror, no statute shall be read as to contradict expressed Presidential orders. It suggests that Section 2340A would be deemed to be unconstitutional if it interfered with the US President's military campaign. Ultimately, this argument does not deny that (some) EITs meet the legal definition of torture but

[60] Bybee (n 43).
[61] ibid.
[62] ibid.

rather claims that the US President could disregard the law, including the prohibition of torture, when responding to the threat of terrorism.

Bybee further claims that the threshold for the severe physical pain or suffering requirement necessary to establish torture would be of a 'level that would ordinarily be associated with a sufficiently serious physical condition or injuries such as death, organ failure, or serious impairment of body functions.'[63] In his view, it was the level of pain or suffering that was crucial in distinguishing lawful interrogation from torture. A higher threshold of severe mental pain or suffering was necessary to prove the latter. This claim was strongly contested by scholars for its erroneous suggestion that the level of pain required should be similar to that experienced during death or organ failure,[64] and that the psychological pain or suffering had to occur over a protracted period and must cause mental harm.[65] Indeed, David D. Cole and David Sussman, professor of law and professor of philosophy respectively, argue that Bybee's analogy to pain that is similar to either death or organ failure is meaningless as neither are associated with a high level of pain *per se*.[66] However, the comparison speaks to our imagination, and as such, helps to associate torture with only the most extreme cases of pain or suffering. Bybee's claim that torture could be established on a scale of pain or suffering, despite being fundamentally flawed, necessitated medical engagement. Only a medically trained professional could differentiate between permissible and impermissible levels of pain or suffering and the possibility of long-term psychological harm.

Finally, Bybee claims that the specific intent to cause such pain or suffering, a prerequisite for acts to meet the legal definition of torture, could be circumvented 'by showing that [the person] had acted in

[63] ibid 6.
[64] David D. Cole, 'The Sacrificial Yoo: Accounting for Torture in the OPR Report' (2010) 4 *Journal of National Security Law and Policy* 455, 457; Jeremy Waldron, 'Torture and Positive Law: Jurisprudence for the White House' (2005) 105 *Columbia Law Review* 1708; Kathleen Clark, 'Ethical Issues Raised by the OLC Torture Memorandum' (2005*) Journal of National Security Law and Policy* 459; David Sussman, 'Defining Torture' (2006) 37 *Case Western Reserve Journal of International Law* 225, 226.
[65] Jordan J. Paust, 'The Second Bybee Memo: A Smoking Gun' (2009) *Jurist* 5; Andrea Birdsall, 'But We Don't Call It "Torture." Norm Contestation During the US War on Terror' (2016) 53 *International Politics* 176.
[66] ibid.

good faith that his conduct would not amount to torture.'[67] He claims that a good faith defence could be established in those cases where the person wishing to rely on the defence had surveyed professional literature, consulted with experts, and reviewed evidence from previous experiences.[68] This is another clear suggestion that a medical professional's opinion on which acts could cause severe mental pain or suffering capable of meeting the definition of torture could negate the required specific intent to torture. Bybee's advice made medical professionals essential to the practice of the EITs since only medical professionals, drawing upon their medical experience, could refute that the pain threshold had been reached and so provide interrogators with the defence of good faith.

Despite the flaws in the US justification, the numerous memoranda were relied upon by the US Administration to enable and justify the stripping of the detainees' legal protections and normalising treatment that fell below any recognised international and domestic minimum standards. While a rich body of scholarship has critically scrutinised the above memoranda and focused on the responsibility of their authors,[69] it has typically not extended to consideration of the responsibilities of all who acted on their authority. Some commentators have criticised the lawyers who wrote the memoranda, highlighting the active role they played in facilitating the abuse suffered by detainees.[70] In this regard, they argue that the memoranda are partisan. They do not review the proposed techniques and scrutinise them critically to ensure their compatibility with domestic and international law obligations but focus on justifying the use of EITs and so finding a case for their use. The memoranda do not consider the other side of the argument, namely the illegality of EITs. Indeed, a detailed critique from legal scholars has targeted the lawyers' failure to meet appropriate standards of impartiality and to

[67] ibid 8.
[68] ibid 8. Bybee cited the decision in *Ratzlaf* v *United States* (1994) 510 U.S. 135. However, it is questionable whether this defence would apply in the case of torture.
[69] Michael P. Scharf, 'The Torture Lawyers' (2009) 20 *Duke Journal of Comparative and International Law* 389; Cherif M. Bassiouni, 'The Institutionalisation of Torture under the Bush Administration' (2006) 37 *Case Western Reserve Journal of International Law* 389; David Cole, 'The Torture Memos: The Case Against the Lawyers' *The New York Review of Books* (New York, 8 October 2009); Jens David Ohlin, 'The Torture Lawyers' (2010) 51 *Harvard International Law Journal* 193.
[70] Scharf (n 69) 389; Christopher Kutz, 'The Lawyers Know Sin: Complicity in Torture' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006) 241; Richard B. Bilder and Detlev F. Vagts, 'Speaking Law to Power: Lawyers and Torture' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006) 151.

ensure conformity with norms of international and domestic law.[71] For example, Jose E. Alvarez, professor of law, correctly notes that the legal opinions misrepresented the US international law obligations.[72] Similarly, Henry Shue and Richard H. Weisberg, professors of law, argue that the lawyers misused the ticking time bomb argument as a way to regulate the use of torture.[73] Harold H. Bruff, Jens David Ohlin, both professors of law, David P. Forsythe, professor of political science, Mark Denbeaux and Jonathan Hafetz, professor of law and practising lawyer respectively, convincingly critique the lawyers for engaging in an end-result focused analysis.[74] Bradley W. Wendel, professor of law, notes that the end-result oriented enquiry is the wrong approach, pursuing the client's interest only, contrary to the lawyers' primary obligation, their fidelity to the law.[75] Similarly, David Cole, professor of law, identifies that the lawyers 'used law, not as a check on power but to facilitate brutality, deployed against captive human beings.'[76]

However, within the literature on the use of torture in the War on Terror, the role of doctors is given scant consideration. For example, M. Cherif Bassiouni, professor of law, predominately focuses on and scrutinises the role of the lawyers in providing legal justification for the use of torture.[77] However, he recognises that others have played contributing roles. He correctly notes that the legal memoranda

[71] Lee A. Casey and David B. Rivkin, Jr., 'Rethinking the Geneva Conventions' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006) 203; David Cole, *The Torture Memos: Rationalising the Unthinkable* (The New Press: New York, 2009); Jose E. Alvarez, 'Torturing the Law' (2006) 37 *Case Western Reserve Journal of International Law* 175; Bilder *et al.* (n 70) 151.
[72] Alvarez (n 71) 179.
[73] Henry Shue, 'Torture in Dreamland: Disposing of the Ticking Bomb' (2006) 37 *Case Western Reserve Journal of International Law* 231, 232; Richard H. Weisberg, 'Loose Professionalism, or Why Lawyers Take the Lead on Torture' in Sanford Levinson (ed.), *Torture: A Collection* (Oxford University Press: Oxford, 2004); David Luban, 'Liberalism, Torture, and the Ticking Bomb' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006) 35.
[74] David P. Forsythe, *The Politics of Prisoner Abuse: The United States and Enemy Prisoners after 9/11* (Cambridge University Press: New York, 2011); Mark Denbeaux and Jonathan Hafetz, *The Guantanamo Lawyers. Inside a Prison Outside the Law* (New York University Press: New York, 2009); Harold H. Bruff, *Bad Advice: Bush's Lawyers in the War on Terror* (University Press of Kansas: Lawrence, 2009); Jens David Ohlin, 'The Torture Lawyers' (2010) 51 *Harvard International Law Journal* 193; Joshua Dratel and Stephen Gillers, 'Torture: The Road to Abu Ghraib and Beyond' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006) 13; Bradley W. Wendel, 'Defence to Clients and Obedience to Law: The Ethics of the Torture Lawyers (A Response to Professor Hatfield)' (2009) 104 *Northwestern University Law Review* 58.
[75] Bradley W. Wendel, *Lawyers and Fidelity to Law* (Princeton University Press: Princeton, 2010) 2.
[76] Cole (n 71) 14.
[77] Bassiouni (n 69) 81.

'allow[ed] their clients[78] to rely on their advice, and thus eventually avoid responsibility.'[79] Bassiouni recognises the involvement of medical professionals in the use of torture in American detention centres. However, he fails to consider how involving medical professionals might shift (part of) the burden for justifying EITs from lawyers or the US Administration onto the medical professionals.

While the focus on lawyers is justified by virtue of the subsequent reliance on their defective legal opinions, the failure to consider the involvement of medical professionals cannot be readily excused. Their participation changed the dynamics of the rationale for torture by providing the scientific justification for its use. It could be argued that if it was not for the involvement of medical professionals, the justification offered by the lawyers might not withstand public scrutiny. As more evidence of medical involvement has begun to surface in recent years,[80] the attention of academic commentators[81] and NGOs[82] has begun to shift from the US Administration and lawyers onto medical professionals. Some of the most vocal academic commentators are medical professionals. Among others, Steven H. Miles has been shedding light on the extent of medical involvement in the EITs and advocating for medical professionals to be held accountable.[83] Others, such as Vincent Iacopino and Stephen Xenakis, both medical professionals, point out that failure to collect evidence of medical involvement is itself a violation of medical professionals' duties to record the treatment of the detainees as patients.[84] The topic may gain more attention after an August 2017 civil suit against two

[78] Clients here are President George W. Bush, Vice President Dick Cheney, Defence Secretary Donald Rumsfeld, and Attorney General John Ashcroft.
[79] Bassiouni (n 69) 403.
[80] Nathaniel Raymond *et al*, 'Experiments in Torture: Evidence of Human Subject Research and Experimentation in the "Enhanced" Interrogation Program' (Physicians for Human Rights, 2010); International Committee of the Red Cross, 'Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody' (2007) 21; Senate Select Committee on Intelligence, 'Committee Study of the Central Intelligence Agency's Detention and Interrogation Program' (3 December 2014) 9.
[81] See for example: Vincent Iacopino and Stephen N. Xenakis, 'Neglect of Medical Evidence of Torture in Guantanamo: A Case Series' (2011) 8 *PLoS Medicine* 4; Leonard S. Rubenstein and Stephen N. Xenakis, 'Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees' (2010) 304 *Journal of the American Medical Association* 569; Anne Daugherty Miles, 'Perspectives on the Senate Select Committee on Intelligence (SSCI) "Torture Report" and Enhanced Interrogation Techniques: In Brief' (2015).
[82] For example: Physicians for Human Rights, Amnesty International, Human Rights Watch.
[83] Steven H. Miles, *Torture Doctors: Human Rights Crimes and the Road to Justice* (Georgetown University Press: Washington DC, 2020).
[84] Iacopino and Xenakis (n 81) 4.

medical professionals, who were architects of EITs, opened the door for other lawsuits.[85] However, at the time of writing this thesis, there were no similar reported cases.

The processes discussed in Section 2 above resulted in the detainees being exposed to treatment that fell below international standards, particularly those recognised in the Geneva Conventions. However, even if the detainees did not benefit from international legal provisions, this did not mean that medical professionals, or others involved in EITs, could act in violation of international legal obligations that did apply to them. In other words, while the changes to detainees' status were intended to strip them of their international law protections, it did not change the obligations of medical professionals or authorise them to act outside of the international legal standards that continued to apply to them, domestic and international law standards that prohibit torture and other criminal and unlawful conduct. Hence, the US Administration found it necessary to take further steps to ensure the protection of medical professionals involved in EITs. They achieved that by redefining the duties of medical professionals in American detention centres.

4. Redefining the Duties of Medical Professionals in American Detention Centres

In 2003, the CIA's Office of Medical Services ('OMS') released a set of guidelines for interrogation[86] advising that the use of EITs should be reviewed and approved in every case individually.[87] The OMS guidelines recommended a proper assessment of harm associated with the use of EITs and the introduction of safeguards that would help to prevent these harms from materialising. They claim that the medical professionals' role was to safeguard detainees from excessive interrogations,[88] with medical professionals to be present during interrogations to ensure that no serious or permanent harm would be inflicted.[89] While the US Administration maintained that the EITs it used were safe and not capable of causing any serious harm, the OMS guidelines from 2003 strongly contradict these

[85] See: *Salim* v *Mitchell*.
[86] Office of Medical Services is the CIA's body.
[87] Institute on Medicine as a Profession and OSF Joint Task Force Guantanamo Bay, 'Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror' (2013) xv.
[88] ibid xv.
[89] ibid.

assurances. For example, the OMS guidelines advised medical professionals and interrogators to keep 'resuscitation equipment and supplies for an emergency tracheotomy' available during waterboarding.[90] If waterboarding and other EITs were safe, such resuscitation equipment should not have been necessary.

However, it did not stop there. As medical professionals were critical in distinguishing lawful interrogation from torture, based on the level of pain or suffering involved, and to the establishment of the good faith defence, the US Administration had to take further steps that would address the issue of their (potential) accountability for these acts. Indeed, the risk of legal and professional accountability could have discouraged medical professionals from engaging in the practice.[91] In order to do so, in June 2005, the Pentagon accepted a new policy based on Dr David Tornberg's[92] proposal that medical professionals working with interrogators were not obliged to adhere to the same medical professional norms as other medical professionals who were not involved in interrogations,[93] despite the fact that this advice was contrary to medical professional norms.[94] Subsequently, in June 2006, the US Department of Defence issued Instruction 2310.08E ('the Instruction'), which applied to medical professionals 'supporting detainees operations.'[95] The Instruction was a major step towards

[90] ibid.

[91] In light of the medical involvement in EITs, the American Medical Association (AMA), the American College of Physicians, and the American Psychiatric Association (APA) affirmed the universally recognised medical ethics applicable in the case. They further affirmed that medical professionals were prohibited from being directly involved in interrogations or provide interrogators with detainees' medical data and affirm their duty to report abuse. However, in 2005, the APA, while affirming the prohibition of torture, confirmed that psychiatrists acting as consultants to interrogations or collecting information used for national security related purposes, are indeed acting within the boundaries of the recognised medical ethics. Faced with criticism, APA subsequently reversed this position, affirming that EITs constituted torture and indicated that psychiatrists were not allowed to 'work where persons are held in violation of international law or the U.S. Constitution unless they work for the detainee or for the protection of human rights.' See: APA, Petition Resolution Policy, Psychologists and Unlawful Detention Settings with a Focus on National Security, 2008; APA, Policy Related to Psychologists' Work in National Security Settings and Reaffirmation of the APA Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, 2013. See also: APA Applauds Release of Senate Intelligence Committee Report Summary, 2014.

[92] David Tornberg, MD, MPH, was the Chief Medical Officer for the Logistics Health Incorporated ('LHI') and a member of LHI's Strategic Advisory Committee.

[93] Gregg M. Bloche and Jonathan H. Marks, 'When Doctors Go to War' (2005) 352 *The New England Journal of Medicine* 3; US Assistant Secretary of Defence, 'Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the US' (2005).

[94] See for example: The American Medical Association (AMA) Code of Medical Ethics states that: 'Medical ethics in times of armed conflict is identical to medical ethics in times of peace.'

[95] US Department of Defence, 'Instruction 2310.08E, Medical Program support for detainee operations' (6 June 2006). Detainee operations is a term that encompasses, among others, the capture, detention, screening, transportation, treatment and protection, housing, transfer of detainees.

transforming the duties of medical professionals in American detention centres. It equipped the US Administration with two main arguments that were designed to protect medical professionals from potential accountability for their assistance in the administration of EITs, namely that 1) the medical professionals were not in a fiduciary relationship with the detainees and 2) where a fiduciary relationship is present, military duties would nonetheless override medical duties.

The Instruction establishes policies for 'medical program support for detainee operations' and 'reaffirms the responsibility of [medical professionals] to protect and treat' all detainees.[96] The Instruction clearly distinguishes between health care personnel (ordinary medical professionals)[97] and behavioural science consultants (the BSCs).[98] While according to the Instruction, ordinary medical professionals were to meet generally recognised medical professional norms, the duties required from, and medical professional norms applicable to the BSCs vary significantly, ultimately placing them outside of legal and medical professional norms. According to the Instruction, the BSCs, allegedly the only medical professionals involved in the use of EITs in American detention centres, were not in a fiduciary relationship with the detainees.[99] The US Administration suggested that only the ordinary medical professionals, who according to the US Administration were not involved in any EIT-related activities, were in a 'provider-patient relationship' with the detainees they treated.[100] Provider-patient relationship is a term used by the US Administration to describe the fiduciary relationship between medical professionals and detainees. The Instruction was a document produced

[96] ibid 1.3.
[97] ibid 2. Health Care Personnel is 'an individual who has received special training or education in a health-related field and who performs services in or for the Department of Defence in that field. A health-related field may include administration, direct provision of patient care, or ancillary or other support services. Health care personnel include, but are not limited to, individuals licensed, certified, or registered by a government agency or professional organisation to provide specific health services. Health care personnel covered by this Instruction include those assigned as BSCs and also include members of the Uniformed Services, civilian employees, and contractor personnel in a health-related field acting in support of any DoD Component.' Ibid.
[98] ibid 2. 'Behavioural Science Consultants (BSCs). Health care personnel qualified in behavioural sciences who are assigned exclusively to provide consultative services to support authorised law enforcement or intelligence activities (similar to behavioural science unit personnel of a law enforcement organisation or forensic psychology or clinical social work practitioners supporting the criminal justice, parole, or corrections systems).'
[99] ibid E2.1. E2.1. states: 'They employ their professional training not in a provider-patient relationship, but in relation to a person who is the subject of a lawful governmental inquiry, assessment, investigation, interrogation, adjudication, or other proper action.'
[100] ibid 1.3.

by the US Department of Defence to establish policy and assign responsibility or implement previously established policy.[101] An instruction is not the vessel by which new laws could be introduced. An instruction should operate within the frameworks of existing laws. As such, where the Instruction contradicts existing law, it would be rendered invalid.

4.1. The Ordinary Medical Professional

The wording of the Instruction suggests that the US Department of Defence recognises the fiduciary relationship owed by medical professionals in general. It says that they are under a 'duty to protect detainees' physical and mental health and provide appropriate treatment for the disease.'[102] It also recognises the existence of their duty:

> in all matters affecting the physical and mental health of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees and to ensure that no individual in the custody or under the physical control of the Department of Defence, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment, in accordance with and as defined in US law.[103]

The Instruction does not define the fiduciary relationship between medical professionals and detainees but instead explains when this fiduciary relationship exists and identifies the specific duties applicable. The absence of an explanation of the US Administration's understanding of the doctor-patient fiduciary relationship should not be ignored. In the absence of any clarification, it is reasonable to argue that it relied upon the ordinary meaning of a fiduciary relationship as it has developed under US jurisprudence and legal doctrine. This is discussed in Chapter Three.

[101] University of Denver Private Security Monitor, 'Department of Defence Regulations and Instructions' http://psm.du.edu/national_regulation/united_states/laws_regulations/defense.html.
[102] Instruction (n 95) 4.1.2.
[103] ibid 4.1.1.

The Instruction clearly distinguishes between the elements of a duty of care, specifies its scope and applicability and attaches the specific duties that may be interpreted as a duty of confidentiality and duty to act in the best interest of the detainees.[104] It notes that the duty of care incorporates the duty to treat detainees and to protect them from abuse (by way of encouraging their humane treatment).[105] While at face value, the duty of care does not deviate from the ordinary duty of care owed by medical professionals to their patients, the Instruction cites several factors that purport to limit its scope. The Instruction recognises a very limited duty to treat a 'disease' and does not discuss whether it covers an injury. It states that 'health care personnel charged with the medical care of detainees have a duty to… provide appropriate treatment for the disease.'[106] This may lead to the conclusion that ordinary medical professionals are under no duty to treat detention inflicted injuries. Alternatively, this may be interpreted as a careful semantic choice, deliberately designed to avoid any suggestion that detainees are likely to suffer injuries while in detention.

According to the Instruction, the scope of the fiduciary relationship applies only to 'evaluation, protection and improvement of the physical and mental health.'[107] This could be read to mean that when medical professionals engage in any activities other than those listed, these activities would not be covered by the usual doctor-patient fiduciary relationship. Furthermore, the Instruction qualifies the duty stating that 'to the extent practicable, treatment of detainees *should be guided* by professional judgments and *standards similar to* those applied to personnel of the US Armed Forces.'[108] This qualification relies on the premise of what is 'practicable.'[109] No clarification is offered, leaving it up to the discretion of the medical professional. The duty is further qualified by the vague language of 'should be guided' and 'standard similar to' that do not prescribe adherence to the existing standards opening the door for an argument that they do not have to comply with them.

[104] ibid 4.1.
[105] ibid 4.1.1.
[106] ibid.
[107] ibid 4.1.3.
[108] ibid 4.1.2. [emphasis added].
[109] ibid.

The duty of confidentiality is confirmed in the Instruction in that medical professionals are not to 'actively solicit information from detainees other than for health care purposes.'[110] As clarified in the document, the duty of confidentiality is not absolute, especially when the breach would aim at 'preventing harm to any person, maintaining public health and order in detention facilities, and any lawful law enforcement, intelligence, or national security-related activity.'[111] This qualification may be within the ambits of US law. This is discussed in Chapter Six, Section 2.3.

Under the Instruction, ordinary medical professionals are prohibited from certifying detainees' fitness for 'any form of treatment or punishment that is not in accordance with applicable law or participat[ing] in any way in the administration of any such treatment or punishment.'[112] This duty may be read to incorporate an implied duty to act in the best interest of the detainees. While assessing fitness is an ordinary medical activity, here, it could facilitate EITs such as waterboarding and so may not be in the best interest of detainees.

Furthermore, the Instruction prescribes that medical professionals should not participate in any procedure that involves physical restraint of the detainees.[113] It is not clear whether this includes physical restraint accompanying forced feeding. If so, this duty may be read as to imply upholding the principle of respect for autonomy. However, the Instruction provides a very broad exception to the rule where 'a procedure is determined to be necessary for the protection of the physical or mental health or the safety of the detainee, or necessary for the protection of other detainees or those treating, guarding, or otherwise interacting with them.'[114] Hence, even if the provision were to apply to physical restraints accompanying forced feeding, the vague wording of the exception might be interpreted as authorising an intervention.

[110] ibid 4.3.
[111] ibid 4.4.
[112] ibid 4.1.5.
[113] ibid 4.1.6.
[114] ibid.

Concerning the issue of consent, the Instruction provides that ordinary medical professionals 'in general… will be provided with the consent of the detainees.'[115] The scenarios where a detainee's consent should be sought are not made clear, especially as the Instructions states that the consent 'will be provided.' It is unclear what this means and whether it refers to obtaining informed consent or may include consent obtained with the use of undue influence or coercion. The general statement is then followed by further examples of how consent can be obtained: the detainees' consent can be implied in emergencies[116] or overridden in the cases of 'hunger-strike, attempted suicide, or other attempted serious self-harm.'[117] It also provides that ordinary standards for obtaining consent may be observed where practicable.[118] Furthermore, the reference to a standard for obtaining consent which may be observed where practicable opens the door to an argument for ignoring the standard as impracticable in all the circumstances.

The Instruction indicates that the assistance provided by ordinary medical professionals to BSCs is not covered by the doctor-patient fiduciary relationship and so narrows the circumstances when, according to the US Administration, the fiduciary relationship could operate between ordinary medical professionals and detainees.[119] According to the Instruction, medical professionals assisting the BSCs are subjected to the same standard as BSCs, this is further discussed below.[120] The Instruction does not clarify what constitutes assistance and how broadly this could be interpreted leaving it open to interpretation and so blurring the line between BSCs and ordinary medical professionals.

The Instruction also confirms that all ordinary medical professionals, regardless of whether or not their actions are covered by the fiduciary relationship, must adhere to 'applicable law or the standards'[121] laid down in the Department of Defence Directive 2310.01E 'The DoD Detainee

[115] ibid 4.7.
[116] Ibid.
[117] ibid 4.7.1.
[118] ibid 4.7.
[119] ibid E2.1.
[120] ibid.
[121] ibid 4.1.4.

Program' of 18 August 1994 ('the Directive').[122] The Directive prescribes that 'all detainees shall be treated humanely and following US law, the law of war, and applicable US policy'[123] and in accordance with international legal provisions.[124] This should affirm the protection of the rights of detainees in line with the laws and policies. However, if the document is to be read in conjunction with the US Administration's legal opinions explaining the law as applicable to American detention centres, as discussed earlier in the chapter, such protections are ultimately denied. Furthermore, as explained in Section 2 above, US law which prohibits torture establishes a higher threshold. This means that certain practices that are recognised as torture under international standards, including some EITs, may not be accepted as torture under the US law and hence may be perceived as legal.[125] As a result, the requirement to adhere to US law and polices, and observance of international law provisions does not preclude the use of practices that may amount to torture (or other criminal conduct, tortious or disciplinary wrongs).

4.2. The Behavioural Science Consultants

According to the Instruction, BSCs were authorised to make psychological assessments of the detainees and to share their findings with and advise the interrogators on the implications of them. The Instruction clarifies that BSCs may provide advice to the interrogators in any case where the interrogation was fully following the applicable law[126] and involved 'properly issued interrogation instructions'[127] but never in cases of unlawful interrogation.[128] However, the analysis in the earlier section shows, according to Bybee, inflicting pain or suffering does not mean that the interrogation is unlawful. The Instruction authorises BSCs to advise the interrogators on 'detainee operations', to provide training[129] and to advise the interrogators[130] as to whether to pause, conclude or continue an

[122] ibid.
[123] ibid 4.1.
[124] ibid 4.2.
[125] ibid 4.1.1.
[126] Here: Section 2340A of the MPC.
[127] Instruction (n 95) E2.1.1.
[128] ibid E2.1.6.
[129] ibid E2.1.3.
[130] ibid E2.1.4.

interrogation.[131] The BSCs were not to provide medical screening and monitor detainees during the interrogation.[132] However, they 'may observe, but shall not conduct or direct interrogations.'[133]

The Instruction prohibits BSCs from using the detainee's physical and mental health information in a way that would lead to the inhumane treatment of the detainee, in breach of applicable law.[134] Lastly, BSCs were not to identify themselves as medical professionals,[135] represent themselves as acting in the best interest of the detainees, or as individuals assisting the interrogators.[136] BSCs were further released from their duty to provide the detainees with medical care and attention unless in emergencies where there were no other medical staff available at the time.[137]

The Instruction provides special standards (and procedures) for the BSCs and ordinary medical professionals assisting the BSCs.[138] The Instruction claims that the BSCs are not in a fiduciary relationship with detainees as:

> health care personnel engaged in non-treatment activities, such as forensic psychology, behavioural science consultation, forensic pathology, or similar disciplines, shall not engage in any professional provider-patient treatment relationship with detainees.[139]

It suggests that BSCs are to 'employ their professional training not in a provider-patient relationship, but in relation to a person who is the subject of a lawful governmental inquiry, assessment,

[131] ibid E2.1.5.
[132] ibid E2.1.9.
[133] ibid E2.1.2.
[134] ibid E2.1.7.
[135] ibid E2.1.8.
[136] ibid.
[137] ibid E2.1.8.
[138] ibid E2.1: 'BSCs are authorised to make psychological assessments of the character, personality, social interactions, and other behavioural characteristics of detainees, including interrogation subjects, and, based on such assessments, advise authorized personnel performing lawful interrogations and other lawful detainee operations, including intelligence activities and law enforcement. They employ their professional training not in a provider-patient relationship, but in relation to a person who is the subject of a lawful governmental inquiry, assessment, investigation, interrogation, adjudication, or other proper action. Requirements in this Instruction applicable to BSCs are also applicable to other health care personnel providing direct support to BSCs.'
[139] ibid 4.3.

investigation, interrogation, adjudication, or other proper action.'[140] However, by doing so, the Instruction may contradict applicable US law, and here, the US law pertaining to a fiduciary relationship. This is considered in Chapters Three and Four.

The Instruction seeks to distance BSCs from any situations that would suggest that the fiduciary relationship could exist. It recognises that medical professionals may transfer from their ordinary medical duties to acting as BSCs; however, this should not happen within three years after serving in the same location unless there are compelling circumstances.[141]

The Instruction recognises one scenario in which BSCs may become subject to the fiduciary relationship: when they act in emergencies to save a life or prevent permanent injuries.[142] According to the Instruction, this will only be the case if there are no other medical professionals who could provide this life-saving medical assistance.[143] However, the Instruction fails to address other situations that should trigger fiduciary relationship even if it is not ordinarily present.[144] Furthermore, to ensure that the fiduciary relationship would not be imposed in all the circumstances, as it is possible under the US law, BSCs are prohibited from acting in a way that may imply such fiduciary relationship, for example:

> BSCs shall not allow themselves to be identified to detainees as health care providers. BSCs shall not provide medical care for staff or detainees (except in emergency circumstances in which no other health care providers can respond adequately to save life or prevent permanent impairment). BSCs shall not provide training in first aid, sanitation, or other health matters.[145]

[140] ibid E2.1.
[141] ibid E.2.1.8.
[142] ibid 4.3.
[143] ibid.
[144] See Chapter Three, Section 3.2.
[145] Instruction (n 95) E.2.1.8.

The Instruction suggests that the medical duties of medical professionals in American detention centres differ depending on the roles undertaken. However, such a distinction may not be in accordance with the law, and as emphasised above, the Instruction must operate within the frameworks of existing laws. This will be put to test in subsequent chapters.

5. Conclusion

This chapter has shown how the US Administration relied on the participation of medical professionals to enable the development and implementation of EITs. While the process of 'normalising' EITs and justifying their use by interrogators explains why the involvement of medical professionals was crucial, it could not exclude the possibility that medical practitioners might be held accountable for their conduct. Hence, the US Administration relied on additional legal analysis in order to justify the involvement of medical professionals at every stage of the preparation and implementation of EITs. This included two key arguments: that 1) there is no doctor-patient fiduciary relationship between some of the medical professionals and the detainees in the American detention centres; and 2) that where medical duties conflict with military ones, then any dual loyalties conflict is to be resolved in favour of the latter. The next chapters explain why these arguments are flawed.

CHAPTER THREE: The Fiduciary Relationship in the US Law

1. Introduction

As things currently stand, medical professionals involved in EITs at American detention centres have not been subject to the same level of scrutiny as other actors such as the CIA agents or the lawyers who provided the legal justification for EITs.[1] The reason for this may be that medical professionals are often perceived as observers who are unable to stop the abuse, or as just another accomplice following orders without any *de facto* power. For years, the US Administration portrayed the presence of medical professionals in American detention centres as both necessary to ensure that the EITs were 'safe, legal, and effective' and insignificant in the EIT practice.[2] However, as more evidence has come to light, it has significantly undermined this picture. This is exemplified in the evidence scrutinised and the taxonomy introduced in Chapter One.

Holding medical professionals accountable in US domestic courts during the Bush Administration was unlikely. It was implausible that the courts would allow cases against the US Administration to proceed, given their ever-growing politicisation.[3] Courts would broadly rely on the argument of the political question doctrine[4] or the Commander-in-Chief's sole authority to decide on matters of national security.[5] However, many human rights advocates hoped that the subsequent administrations may take a more proactive approach to the issue, especially as Barack Obama, a senator at the time, was very critical of the use of torture as a means of conducting the War on Terror. He called to end

[1] See Chapter Two. However, it is noteworthy that the issue of accountability has been raised by several medical professionals (including Steven H. Miles) and non-governmental organisations (including the Physicians for Human Rights, ACLA etc.).
[2] Jay S. Bybee, 'Memorandum to Alberto R. Gonzales' (2002); John C. Yoo, 'Memorandum to William J. Haynes II' (2003).
[3] John Ferejohn, 'Judicializing Politics, Politicizing Law' (2002) 65 *Law and Contemporary Problems* 41.
[4] The political question doctrine has the effect of undermining the otherwise present separation of powers and has been used in controversial cases concerning foreign policy. See: *Tel-Oren* v *Libyan Arab Republic* (1984) 726 F.2d 774, 803; *Al-Aulaqi* v *Obama* (2010) 727 F.Supp.2d 1, 52; *Ange* v *Bush* (1990) 752 F. Supp. 509, 514.
[5] Article II, Section 2 of the US Constitution in Conjunction with Congress' Authorisation for Use of Military Force against Terrorists. See: *Youngstown Sheet & Tube Co.* v *Sawyer* (1952) 343 U.S. 579 and the subsequent challenge in *Rasul* v *Bush* (2004) 542 U.S. 466, *Hamdan* v *Rumsfeld* (2006) 548 U.S. 557.

it.[6] Once President, however, Obama did little towards bringing those responsible to account. The most significant action of his Administration was to release a summary of the SSCI report,[7] which declassified a significant amount of information which was not previously available. This opened the door for the first-ever successful legal challenge.[8]

Nonetheless, the Obama Administration confirmed that it would not seek to hold those involved accountable. It relied on the argument that the Bush Administration considered EITs to be legal at the time (based on the US Department of Justice legal opinion on international and domestic law discussed in Chapter Two), creating an atmosphere of impunity whereby those involved in the EITs, including medical professionals, should not expect to face legal accountability for their involvement.[9] Indeed, it continued to rely on that argument even after the launch of the SSCI report, which conclusively rebutted it. Indeed, the argument of EITs being 'legal at the time' is incorrect. EITs were considered legal only because they were supported by a legal opinion that was fundamentally flawed.[10] The existence of such a legal opinion does not make EITs legal.

Any future consideration of accountability, whether criminal, civil or disciplinary, of medical professionals would depend, among other things, on the political will of future administrations to deal with past wrongs, and upon the availability and quality of evidence. However, as this thesis argues, critically, it would also depend on the ability to successfully rebut the US Administration's justification for medical involvement. The first key argument centres on the US Administration's claim that there is no fiduciary relationship between medical professionals and detainees in American detention centres. The second key argument is the idea that a medical professional's duty towards the

[6] Malathi Nayak, 'Factbox: Has Obama Delivered on His 2008 Campaign Promises?' *Reuters* (28 October 2011); Peter Finn, 'Guantanamo Closure Called Obama Priority' *Washington Post* (Washington DC, 12 November 2008). This was also clear from Obama's Executive Order No. 13492 of 22 January 2009. Executive Order 13492 on 'Review and Disposition of Individuals Detained at the Guantanamo Bay Naval Base and Closure of Detention Facilities' was meant to, among others, close the Guantanamo detention centre and also review humane standards of confinement.
[7] See Chapter One, Section 3.4. for more details.
[8] See *Salim* v *Mitchell*.
[9] See for example: John O. Brennan, 'Statement on SSCI Detention and Interrogation Program' (11 December 2014).
[10] See Chapter Two, Section 2 for a detailed analysis.

state overrides any duties towards detainees (as patient). Chapters Three and Four challenge the first of these claims, while Chapters Five and Six take up the second.

This chapter argues that the nature of the relationship between medical professionals and detainees in American detention centres is pivotal to many of the different types of legal accountability of medical professionals, including those involved in the administration of EITs in American detention centres. In order to build this argument, this chapter sets out the existing US law on when a fiduciary relationship is owed and when it is not owed. It begins by discussing why the existence of a fiduciary relationship matters and what the practical implications of the fiduciary relationship between medical professionals and patients are (Section 2). It argues that the existence of the fiduciary relationship between medical professionals and detainees affects their duties towards the detainees and opens up otherwise unavailable avenues of legal action. The chapter then sets out how the fiduciary relationship is attached under US law (Section 3). It further considers the limitations to such a relationship, including the limited circumstances in which it is not owed by a medical professional to those encountered in their professional practice, and in cases where the fiduciary relationship is established, when it ends, and what it means for the potential accountability of medical professionals (Section 4).

2. Why Does the Existence of the Fiduciary Relationship Matter?

The medical profession is highly regulated with doctors subject to criminal laws, civil laws, and medical professional disciplinary norms.[11] Such regulations are reflective of the nature of the medical profession and the potential consequences that negligence has for patients. It follows that where, in the due course of a medical procedure or treatment, a patient is facing a risk to their life or health, the relationship between a medical professional and a patient should be strictly regulated. These regulations ultimately define the obligations of medical professionals, the consequences of failing to

[11] Mark A. Hall, Mary A. Bobinski and David Orentlicher, *Medical Liability and Treatment Relationships* (Aspen Publishers: New York, 2008).

meet them, the rights of patients and the remedies when duties are breached.[12] Due to the nature of medical work and its inherent risks, the majority of scholarly commentators consider the doctor-patient relationship to be fiduciary in nature and as such, to provide an extra level of protection to patients.[13] This analysis is also accepted by some courts.[14] Although in three states, Alabama,[15] Delaware,[16] and Minnesota,[17] courts have decided against recognising the doctor-patient relationship as fiduciary. Furthermore, as Maxwell J. Mehlman, professor of law, notes, ten other states, while accepting the relationship as fiduciary, do not recognise that the patient (as the claimant) would have a cause of action for breach of the fiduciary relationship separate from action for malpractice.[18]

As Mehlman correctly notes, the doctrine of the fiduciary relationship emerged as the courts' response to 'the absence of a remedy in early common law for beneficiaries injured by the disloyalty of trustees.'[19] As such, the role of the fiduciary relationship continues to exist with 'fiduciary rules designed to ensure that the fiduciary fulfils his or her obligations and does not neglect, abuse, exploit, or otherwise take advantage of the relatively vulnerable and dependent beneficiary.'[20] These rules

[12] Marc A. Rodwin, 'Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System' (1995) 21 *American Journal of Law and Medicine* 243.
[13] See for example: Thomas L. Hafemeister and Sarah Payne Bryan, 'Beware Those Bearing Gifts: Physicians' Fiduciary Duty to Avoid Pharmaceutical Marketing' (2009) 57 *University of Kansas Law Review* 491, 520; Paul D. Finn, 'The Fiduciary Principle' in Timothy G. Youdan (ed.), *Equity, Fiduciaries and Trusts* (Carswell: Toronto, 1989) 33; Edwin C. Hui, 'The Patient-Surgeon Relationship. Part II: Medical Fidelity as Morality and Law' (2005) 17 *Asian Journal of Oral and Maxillofacial Surgery* 210; Edwin C. Hui, 'The Patient-Surgeon Relationship. Part II: Medical Fidelity as Morality and Law' (2005) 17 *Asian Journal of Oral and Maxillofacial Surgery* 210; Cecil Helman, 'Introduction: The Healing Bond' in Cecil Helman (ed.) *Doctors and patients. An Anthology* (Radcliffe Medical Press: Abingdon, 2003) 1; Mike Magee, 'Relationship-Based Health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan. A Comparative Study of Patient and Physician Perceptions Worldwide' (2003) 7 *The Journal of Biolaw and Business*.
[14] Maxwell J. Mehlman, 'Why Physicians are Fiduciaries for their Patients' (2015) 12 *Indiana Health Law Review* 3.
[15] *Gunter* v *Huddle* (1998) 724 So.2d 544, 546.
[16] *McMahon* v *New Castle Assocs*. (1987) 532 A.2d 601, 604.
[17] *Carlson* v *SALA Architects, Inc*. (2007) 732 N.W.2d 324, 331.
[18] Mehlman (n 14) 3, 10. Citing *Hales* v *Pittman* (1978) 576 P.2d 493, 497; *Murillo* v *Millner* (2010) No. D055984, 2010 WL 4730396, 7; *Spoor* v *Serota* (1992) 852 P.2d 1292, 1294-95; *Kernke* v *Menninger Clinic, Inc.* (2001) 172 F.Supp.2d 1347, 1354; *Colton* v *Dewey* (1982) 321 N.W.2d 913, 917; *Garcia* v *Coffman* (1997) 946 P.2d 216, 223; *Lykins* v *Miami Valley Hosp*. (2004) 811 N.E.2d 124; *Gomez* v *Diaz* (2001) 57 S.W.3d 573, 581; *Hansen* v *Rogers* (2003) 119 Wash. App. 1064, 7.
[19] Maxwell J. Mehlman, 'Dishonest Medical Mistakes' (2006) 59 *Vanderbilt Law Review* 1147. See also: Kim Johnston, Patient 'Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives' (1998) 35 *San Diego Law Review* 951, 958.
[20] Hafemeister and Payne Bryan (n 13) 491, 520.

exist 'because of the dependence and vulnerability of the beneficiary and the level of trust imbued in the fiduciary.'[21] In *Mead* v *Adler*, Justice Wollheim reasoned that the fiduciary relationship is a:

> special relationship [that] arises out of the responsibility of one person to act on behalf of and in the best interests of the other. An implicit aspect of the special relationship is that it is consensual – the party to whom the duty is owed authorises the party who owes that duty to exercise independent judgment on the former party's behalf, and the party who owes the duty voluntarily assumes that responsibility.[22]

The fiduciary relationship, aside from the duty to act in the best interest of the other, also incorporates duties of loyalty,[23] acting in good faith,[24] and confidentiality.[25]

While the existence of a doctor-patient fiduciary relationship is broadly accepted, some legal scholars have moved away from the fiduciary model. For example, Patricia Peppin, professor of law, suggests that in light of the move away from a more paternalistic model of medical practice, the fiduciary model may no longer be suited to define the relationship.[26] Suzanne Ost, professor of law, has likewise argued that 'for some patients, knowing that their doctor is legally obliged to respect their autonomy could also diminish (although not extinguish) the need for trust in the relationship, thereby calling into question the existence of an element so fundamental to fiduciary obligations.'[27] A small number of other authors have claimed that the relationship is contractual rather than fiduciary in nature.[28]

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[21] ibid 524.
[22] *Mead* v *Adler* (2009) 231 Or App 451, 220 P3d 118. Finn (n 13) 33; Hui (n 13) 210.
[23] *Woolley v. Henderson*, 418 A.2d 1123, 1128 n.3 (Me. 1980)
[24] *Taber v. Riordan*, 403 N.E.2d 1349, 1353 (Ill. App. Ct. 1980).
[25] *Mull v. String*, 448 So. 2d 952, 953 (Ala. 1984): 'Alabama recognizes a cause of action for breach of fiduciary duty… resulting from a physician's *unauthorized disclosure* of information acquired during the physician-patient relationship.'
[26] Patricia Peppin, 'A Feminist Challenge to Tort Law' in Anne Bottomley (ed.), *Feminist Perspectives on the Foundational Subjects of Law* (Routledge Cavendish: London, 1996) 82.
[27] Suzanne Ost, 'Breaching the Sexual Boundaries in the Doctor-Patient Relationship: Should English Law Recognise Fiduciary Duties?' (2016) 24 *Medical Law Review* 2.
[28] See for example: Paul Sieghart, 'Professional Ethics - For whose Benefit' (1982) 8 *Journal of Medical Ethics* 25, 26; Mark S. Komrad, 'A Defence of Medical Paternalism: Maximising Patients' Autonomy' (1983) 9 *Journal of Medical Ethics* 38. See also: Michelle M. Mello, David M. Studdert, Allen B. Kachalia *et al*., '"Health Courts" and Accountability for Patient Safety' (2006) 84 *The Milbank Quarterly* 459. See also: Heyward H. Bouknight, 'Between the Scalpel and the

The existence or absence of a fiduciary relationship is important for establishing the legal accountability of medical professionals, whether disciplinary, civil, or criminal.[29] While the existence of the fiduciary relationship can strengthen existing legal actions or enable legal actions otherwise unavailable, ultimately, the appropriate legal avenue depends on the level of wrongdoing and the remedy sought. The below sections discuss the importance of the fiduciary relationship for different modes of accountability.

2.1. Disciplinary Proceedings

All medical professionals are subject to various professional standards of practice, regulated by state medical licensing bodies[30] and both domestic and international medical associations.[31] The existence of a fiduciary relationship is a central feature of these responsibilities. It prescribes the duties that doctors owe and the consequences if those duties are breached. For example, Tanya J. Dobash, a practising lawyer commenting upon cases of doctor-patient sexual contact emphasised that:

> Courts evaluating medical licensing board disciplinary actions based on physician-patient sexual contact increasingly have considered… the fiduciary nature of the physician-patient relationship, and the power dynamics within the professional relationship that deprive the patient of the ability to give true consent to sexual contact with the physician.[32]

As the relationship manifests a glaring power imbalance between the parties, the existence of such a relationship also presupposes the possibility of abuse flowing from the power imbalance. A risk that the patient needs protection from. Once a fiduciary relationship is established, apart from adhering to and being accountable for breaches of other legal or professional duties, medical professionals can be

Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence' (2003) 60 *Washington and Lee Law Review* 1530.

[29] Hall *et al.* (n 11).

[30] Drew Carlson and James N. Thompson, 'The Role of State Medical Boards' (2005) 7 *Virtual Mentor* 311.

[31] See: AMA Code of Medical Ethics, World Medical Association (WMA) International Code of Medical Ethics.

[32] Tanya J. Dobash, 'Physician-Patient Sexual Contact: The Battle Between the State and The Medical Profession' (1993) 50 *Washington and Lee Law Review* 1728.

disciplined by a relevant authority for any breach of their fiduciary duties to their patients.[33] A breach of the fiduciary duties may translate into a breach of professional standards of practice, such as unprofessional conduct, and so result in disciplinary action.[34]

Furthermore, the existence of a fiduciary relationship extends disciplinary recourse even after the relationship ceases. For example, in *Haley* v *Medical Disciplinary Bd.*, a case which involved sexual contact between a medical professional and a patient months after the treatment ended, the court affirmed that this was a breach of the fiduciary relationship, capable of a disciplinary action by the state medical board.[35] As such, the existence of a fiduciary relationship forms the foundation for disciplinary action against medical professionals, both during the relationship, and sometimes after the relationship comes to an end.

2.2. Civil Proceedings

The same wrongdoing can also be framed as a civil claim in negligence, breach of contract, or as a breach of a fiduciary relationship where the outcome would be similar (namely, damages).[36] However, as there is a lower threshold for claims of breach of fiduciary duties, resorting to them may improve a claimant's chances of success when compared to other civil actions. For example, in the case of a medical malpractice action, a medical professional must be in breach of a recognised standard of care, while the violation of a fiduciary obligation does not have to be weighed against such standard.[37] The existence of the doctor-patient fiduciary relationship also adds an extra level of protection for the benefit of the patient, in creating the possibility of a claim for breach of the fiduciary

[33] Mehlman (n 19) 1146; Barry R. Furrow, Thomas L. Greaney, Sandra H. Johnson *et al*., *Health Law* (West Group, 2000) 75. See also: Illinois Compiled Statutes Annotated I 60/22(AX14) (West 1993) prescribes that a breach of fiduciary duty, here acting in the best interest of the patient (and not self-interest) is grounds for disciplinary action.
[34] Nadia N. Sawicki, 'Character, Competence, and the Principles of Medical Discipline' (2010) 13 Journal of Health Care Law and Policy 293, 305. See also: Darren Grant and Kelly C. Alfred, 'Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards' (2007) 32 Journal of Health Politics, Policy and Law 876.
[35] *Haley* v *Medical Disciplinary Bd.*, (1991) 818 P.2d 1062.
[36] Although, as discussed above, a claim for breach of the fiduciary relationship is more beneficial in damages. Weissbrodt *et al.* (n 50) 72.
[37] ibid. See also: Caroline Forell and Anna Sortun, 'The Tort of Betrayal of Trust' (2009) 42 *Michigan Journal of Law Reform* 557, 565.

duty.[38] Indeed, a claim for breach of a fiduciary relationship may succeed even if other civil claims fail. This is because, as Dayna Bowen Matthew, professor of law and public health, notes, 'procedurally, fiduciary law places a reduced burden of proof upon plaintiffs making out a prima facie case.'[39] The patient (as the claimant) must show that the fiduciary relationship existed and that it was breached.[40] Thomas L. Hafemeister and Sarah Payne Bryan, professor of law and practising lawyer respectively, suggest that in an action for breach of fiduciary duties, the causation[41] and damage requirements are relaxed.[42]

For example, for a medical malpractice claim to succeed, four elements must be established: a duty of care, breach, causation, and damages.[43] The fiduciary relationship is the cornerstone of the duty of care owed in a malpractice suit. But for the fiduciary relationship, the medical professional would not hold a duty of care that gave rise to the negligent act.[44] Conversely, as Patrick S. Cassidy, a practising lawyer argues, 'by alleging malpractice for a breach of fiduciary duty, the patient may have recourse against the [doctor] if his actions were improper.'[45] The existence of a fiduciary relationship between a medical professional and a patient triggers extra obligations.[46] It also provides for the highest standard of conduct that can be imposed by law.[47] This is on top of any other legal

[38] Dayna Bowen Matthew, 'Implementing American Health Care Reform: The Fiduciary Imperative' (2011) 59 *Buffalo Law Review* 715, 733. *See also:* Jonathan J. Frankel, 'Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures' (1994) 103 *Yale Law Journal* 1297, 1315; Joseph H. King, Jr., 'In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula' (1975) 28 *Vanderbilt Law Review* 1213, 1234-36; Allan H. McCoid, 'The Care Required of Medical Practitioners' (1959) 12 *Vanderbilt Law Review* 549, 558-59. *Lownsbury* v *VanBuren* (2002) 762 N.E.2d 354, 357-58; *Hunter* v *Brown* (1971) 484 P.2d 1162, 1166; *Berkey* v *Anderson* (1969) 82 Cal. Rptr. 67, 78.

[39] Bowen Matthew (n 38) 735; Brian M. Serafin, 'Comparative Fault and Contributory Negligence as Defences in Attorney Breach of Fiduciary Duty Cases' (2008) 21 *Georgetown Journal of Legal Ethics* 993, 994-995.

[40] ibid. Restatement (Third) of § 8.01 d (1) (2006).

[41] Generally, the patient may not need to show actual harm. This 'is in part because (1) the breach of loyalty is the harm and (2) the purpose behind recognizing breach of fiduciary duty claims is to remove the incentive for disloyal conduct on the part of the fiduciary… not necessarily to restore beneficiaries to their position ex ante by compensating their losses.' Hafemeister and Payne Bryan (n 13) 524.

[42] Bowen Matthew (n 38) 735; Serafin (n 39) 994.

[43] Nathalie De Fabrique, 'Medical Malpractice' in Jeffrey S. Kreutzer, John DeLuca, and Bruce Caplan (eds.), *Encyclopedia of Clinical Neuropsychology* (Springer: New York, 2011) 114; *Reynolds* v *Decatur Memorial Hospital* (1996) 660 N.E.2d 235, 239.

[44] See for example: *Church* v *Perales* (2000) 39 S.W.3d 149, 164. 'The existence of a physician's duty arises out of the professional relationship between the physician and his or her patient.'

[45] Patrick S. Cassidy, 'The Liability of Psychiatrists for Malpractice' (1974) 36 *University of Pittsburgh Law Review* 118.

[46] Rodwin (n 12) 243.

[47] Nicolas P. Terry, 'Physicians and Patients Who "Friend" and "Tweet" Constructing a Legal Framework for Social Networking in a Highly Regulated Domain' (2010) 43 *Indiana Law Review* 285, 304.

duties they would ordinarily have.[48] As Hafemeister and Bryan assert, 'fiduciary rules are designed to ensure that the fiduciary fulfils his or her obligations and does not neglect, abuse, exploit, or otherwise take advantage of the relatively vulnerable and dependent beneficiary.'[49] Furthermore, actions for breach of the fiduciary relationship place the beneficiary in a better position than actions for medical malpractice (or any other legal actions) in that 'plaintiffs can access equitable remedies by merely showing that a fiduciary obligation existed and was breached.'[50] In practice, US courts have found the action for the breach of fiduciary duty more beneficial because of the lower burden of proof required.[51] Furthermore, an action for breach of fiduciary relationship allows more flexibility in terms of damages available for the cause of action.[52]

2.3. Criminal Proceedings

The existence of the fiduciary relationship is not a critical element of criminal liability. However, some breaches of the fiduciary relationship can be framed as crimes under US law. A common example would be a breach of the fiduciary duty to act in the best interest of the patient where the breach results in the death of the patient, whether by an act or omission. This amounts to criminal negligence. Medical professionals in the US have been sanctioned for failure to treat a patient in an emergency.[53] Likewise, a failure to provide medical care, where a fiduciary relationship exists, may be treated as a crime.

Similarly, a breach of confidentiality can be framed as tortious or criminal. A medical professional will violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) if they engage in prohibited conduct if they knowingly obtained or used HIPAA-protected information without

[48] *Lockett* v *Goodill* (1967) 430 P.2d 589, 591. See also: Michael Cahill and Peter Jacobson, 'Applying Fiduciary Responsibilities in the Managed Care Context' (2000) 26 *American Journal of Law and Medicine* 155.
[49] Hafemeister and Payne Bryan (n 13) 519, 520.
[50] ibid. Serafin (n 39) 995.
[51] ibid.
[52] ibid. 'Damages for breach of contract are limited to economic losses, omitting compensation for emotional distress or loss of employment.'
[53] Paul Jung, Peter Lurie and Sidney M. Wolfe, 'US Physicians Disciplined for Criminal Activity' (2006) 16 *Journal of Law and Medicine* 335.

authorisation.[54] In one recent case involving a criminal violation of HIPAA,[55] a medical professional was found guilty of a criminal breach of confidentiality for providing a pharmaceutical salesperson with access to his patient's medical data to assist with persuading the patient's insurer to pay for the drugs.[56] Another breach of the fiduciary duty – false reporting – may also result in criminal charges. For example, in one case, a medical professional was convicted of knowingly and wilfully preparing and delivering two false medical reports to the US Immigration and Naturalisation Service.[57] This constituted a breach of his duty to report truthfully and accurately.[58] Finally, the existence of the fiduciary relationship also plays a significant role in sentencing, where it may trigger a higher sentence for the same crime, by virtue of the special relationship as compared to a situation where there is no fiduciary relationship.[59]

There is yet another aspect of the fiduciary relationship that matters for holding medical professionals accountable for their criminal conduct. Some scholars, including Tan and Ost,[60] have argued that a greater reliance on the fiduciary relationship (and legal avenues for its breach) may assist in holding medical professionals accountable. They argue that pursuing a claim for breach of the fiduciary relationship in response to criminal conduct has a higher prospect of success, even where the criminal route would normally fail because of the higher thresholds of proof applicable. Ost, for example, argues that:

> A doctor who proceeds to breach the sexual boundaries has not only violated the patient's trust, he has also failed to respect the mutuality of the doctor-patient

[54] Anne M. Murphy, Laura B. Angelini and Jared Shwartz, 'Criminal Prosecution for Violating HIPAA: An Emerging Threat to Health Care Professionals' *STAT News* (2 July 2018).
[55] HIPPA provides for disciplinary, civil and criminal consequences, namely damages as a civil penalty for knowingly violating HIPPA.
[56] Marianne Kolbasuk McGee, 'Former Physician Convicted of Criminal HIPAA Violation' *Careers Info Security* (4 May 2018).
[57] Jung *et al.* (n 53).
[58] ibid.
[59] Erich D. Andersen, 'Enhancement for Abuse of a Position of Trust under the Federal Sentencing Guidelines' (1991) 70 *Oregon Law Review* 181; Perter Cashman, 'Medical Benefit Fraud: Prosecution and Sentencing of Doctors, Part 1' (1982) 7 *Legal Services Bulletin* 58.
[60] David Tan, 'Sexual Misconduct by Doctors and the Intervention of Equity' (1997) 4 *African Journal of Laboratory Medicine* 243; Ost (n 27).

> relationship, treating the patient not as an autonomous partner but as a means to achieve his self-interest.[61]

While David Tan, professor of law, and Ost, focus only on cases of sexual misconduct, their approach might also be extended to the case of medical professionals involved in EITs, whether amounting to torture or other forms of misconduct. Understandably, the self-interest pursued in the two cases will differ, being financial, career-related or other in the case study of this thesis, rather than sexual as in Tan and Ost's study. However, the underlying principle would be the same in that:

> the doctor takes advantage of the power entrusted in him by both patient and society, prioritising his own interest(s), and may also take advantage of some weakness, vulnerability, or other characteristics that enable him to misuse the patient.[62]

In the case study of this thesis, medical professionals would exploit the detainee's trust in abusing their medical data in breach of their duty of confidentiality in order to expose them to harm.

Ost correctly notes the emerging need to adopt 'a liberal approach to finding fiduciary obligations which draw upon the moral and social purposes that fiduciary law can serve and utilises fiduciary law as an instrument of public policy.'[63] A legal action grounded in the existence of a fiduciary relationship is best suited to address situations where 'the doctor allows conflict between his duty of loyalty to the patient and his own self-interest to arise, gaining from the exploitation of his more powerful position and breach of trust.'[64] Ost convincingly argues that 'the fiduciary approach is grounded in particular professional responsibilities to avoid abuse of trust and power and to prevent conflict arising between the duty to act in the patient's interests and the doctor's own self-interest.'[65] However, equally, if not more plausible, one can argue that, in the case study of this thesis, medical

[61] Ost (n 27).
[62] ibid 211.
[63] ibid 228. See also: Finn (n 13) 26-27.
[64] ibid 288.
[65] ibid 230.

professionals are driven by their duty to the state. This raises a separate argument about dual loyalties, which Chapters Five and Six deal with.

Thus, the existence of a fiduciary relationship has a significant effect on the accountability of medical professionals. In principle, this should be no different in American detention centres. As such, the US Administration has good reason to seek to limit or preclude the existence of a fiduciary relationship as a means of avoiding medical professionals from being held accountable for their role in EITs. However, the Instruction, that sought to limit the existence of a fiduciary relationship, must reflect existing law and does not have the power to change it.[66] Where it does not accurately reflect existing law, the conflicting parts are invalid. The following section now considers existing US laws pertaining to the doctor-patient fiduciary relationship against the guidance contained in the Instruction.

3. What does US Law say about the Fiduciary Relationship and how Accurately does the Instruction Represent it?

The existence of a fiduciary relationship does not follow a person's description or status.[67] As Paul D. Finn, professor of law and former judge, puts it, someone 'is not subject to fiduciary obligations because he is a fiduciary; it is because he is subject to them that he is a fiduciary.'[68] Similarly, James Edelman, scholar and judge, correctly notes that 'the label "fiduciary" is a conclusion which is reached only once it is determined that particular duties are owed.'[69] Accordingly, the fiduciary relationship needs to be established or imposed in each case. The fiduciary relationship can be established where a medical professional[70] accepts or assumes a duty of care towards a patient, or it

[66] US Department of Defence, 'Instruction 2310.08E, Medical Program support for detainee operations' (6 June 2006) 2. The Instruction is a document produced by the department itself (for internal use) to establish policy and assign responsibility or implement previously established policy. Such an instruction, as many other Department of Defence issuances, is legally binding. Any instruction can be modified by the Department of Defence commanders through Fragmentary Orders. Nonetheless, an instruction does not introduce new laws and is to operate within the frameworks of existing laws. See: University of Denver Private Security Monitor, 'Department of Defence Regulations and Instructions.' Available at: http://psm.du.edu/national_regulation/united_states/laws_regulations/defense.html.
[67] Paul D. Finn, *Fiduciary Obligations* (Law Book Co.: Sydney, 1977) 2.
[68] ibid 2. *Bristol & West Building Society* v *Mothew* (1998) Ch. 1 CA, 18.
[69] James Edelman, 'When Do Fiduciary Duties Arise?' (2010) 126 *Law Quarterly Review* 302.
[70] Whether a physician, a psychologist, a nurse or others.

can be imposed by the courts.[71] This section scrutinises the legal basis for these two methods of attaching a fiduciary relationship. In setting out the existing law, it also identifies the points of conflict with the Instruction that will be given further consideration in Chapter Four.

3.1. Establishing the Fiduciary Relationship

Under US law, there is no affirmative duty placed on a medical professional to treat an individual if there is no fiduciary relationship between them.[72] The fiduciary duty must be accepted or assumed. As such, a medical professional having lunch in a restaurant is not under a legal duty *per se* to help a choking customer. In *QT, Inc.* v *Mayo Clinic Jacksonville,*[73] the court clarified that the fiduciary relationship is 'a consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient.'[74] Accepting the fiduciary relationship is the most straightforward method of attaching fiduciary responsibility. However, the courts also recognise that fiduciary relationships can be established in other ways, for example, by way of assuming a duty of care. In the case of *Mead* v *Adler,*[75] the court found that 'in the absence of an express agreement by the physician to treat a patient, a physician's assent to a physician-patient relationship can be inferred when the physician takes an affirmative action concerning the care of the patient.'[76] Such affirmative actions would include the medical professional 'examining, diagnosing, treating, or agreeing to do so.'[77]

Establishing the fiduciary relationship where a duty has been assumed can be challenging, as it may have to be inferred from the situation.[78] The assumption of the fiduciary relationship needs to be

[71] David Hayton, Paul Matthews and Charles Mitchell, *Underhill and Hayton Law of Trusts and Trustees* (Butterworths Law, 2010); Paul B. Miller, 'The Fiduciary Relationship' in Andrew S. Gold and Paul B. Miller, *Philosophical Foundations of Fiduciary Law* (Oxford University Press: Oxford, 2014) 74; *Lac Minerals Ltd* v *International Corona Resources Ltd*. (1989)2 SCR 574 (SCC) 646.
[72] Hall *et al*. (n 11); *Hurley* v *Eddingfield* (1902) 156 Ind. 416, 59 N.E. 1058.
[73] *QT, Inc.* v *Mayo Clinic Jacksonville* (2006) U.S. Dist. LEXIS 33668.
[74] ibid.
[75] *Mead* v *Adler* (2009) 321 Or App 451.
[76] ibid 458.
[77] Stephen C. Bush, 'Formation of the Physician-Patient Relationship: The Oregon Court of Appeals Clarifies, but Questions Remain.' (2010) 13 *Physician Organizations* 11. See also: *Kelley* v *Middle Tennessee Emergency Physicians* (2004) 133 SW3d 587, 596.
[78] This again needs to be distinguished from situations where the fiduciary duty will be imposed.

distinguished from cases where a fiduciary relationship is imposed. In order to establish that a duty has been assumed, we would need to be able to establish relevant intent on the part of the medical professional while the imposition of the duty would refer to cases where intent cannot be established but the circumstances are such that imposing the duty is justified.[79] The analysis of attaching the fiduciary relationship to the case study is discussed in Chapter Four.

The Instruction recognises that there are some cases where the fiduciary relationship is present, namely, between ordinary medical professionals and detainees.[80] It further briefly refers to cases where medical professionals would have assumed a fiduciary relationship, namely, where BSCs are forced in an emergency to conduct a lifesaving procedure and there are no other medical professionals who can release them from this duty.[81] In any other situation where a BSC might become involved, or another ordinary medical professional assisting the BSC, the Instruction denies that a fiduciary relationship can be attached.

The Instruction thus offers a very narrow interpretation of US law and the methods by which a fiduciary relationship can be attached. It seeks to limit them to a few scenarios only, as explained above. The following will argue that this understanding is too narrow and that US law would recognise the existence of a fiduciary relationship far more frequently than is implied by the Instruction. To take just one example: it proposes that the BSCs' duty to provide treatment in emergencies applies only where there is no other medical professional that could provide the treatment. As the chapter will later show, the BSC would be placed under a duty to assist the detainee in emergencies without the extra qualifying element that no other medical professional was present for the duty to be triggered.

3.2. Imposing a Fiduciary Relationship

[79] See Section 3.2. below.
[80] Instruction (n 66) 4.1.1.
[81] ibid 4.3.

Under US law, even where a fiduciary relationship has not been deliberately accepted or assumed by a medical professional, it can be imposed by courts in scenarios where the circumstances justify such attachment.[82] This has occurred in a broad range of scenarios to ensure that medical professionals act in good faith,[83] in the best interest of their patients,[84] or to protect patients, for example, from unnecessary medical treatment.[85] The rationale behind imposing the fiduciary relationship is to recognise and address the power imbalance between the parties and the vulnerable position occupied by the patients within the relationship. Indeed, Hafemeister and Selina Spinos, practising lawyer, correctly note that:

> because patients are so vulnerable and dependent on their physicians, the law imposes a "trust" on doctors – a fiduciary responsibility stemming from the dependence and vulnerability of the patient, and from the disparity between a patient's and a physician's knowledge and ability to act.[86]

Hafemeister and Payne Bryan note that:

> the fiduciary duty doctrine was applied to trustees to control three aspects of the typical trustee-beneficiary relationship: the disparity of knowledge between the trustee and the beneficiary, the trustee's ability to act relatively unilaterally, and the vulnerability and dependence of the beneficiary on the trustee.[87]

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[82] Peter Birks, 'The Content of Fiduciary Relationship' (2000) 34 *Israel Law Review* 19. See also: Leonard I. Rotman, 'Fiduciary Doctrine: A Concept in Need of Understanding' (1995) 34 *Alberta Law Review* 821; Matthew Harding, 'Trust and Fiduciary Law' (2013) 33 *Oxford Journal of Legal Studies* 81, 85; Anthony Duggan, 'Contracts, Fiduciaries, and the Primacy of the Deal' in Elise Bant and Matthew Harding (eds.), *Exploring Private Law* (Cambridge University Press: Cambridge, 2010) 278.
[83] *Forziati* v *Bd. of Registration in Med.* (1955) 128 N.E.2d 789, 791-92.
[84] *Ison* v *McFall* (1964) 400 S.W.2d 243, 258.
[85] *Garcia* v *Coffman* (1997) 946 P.2d 216, 218, 223.
[86] Thomas L. Hafemeister and Selina Spinos, 'Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient' (2009) 86 *Washington University Law Review* 1167, 1187; Hafemeister and Payne Bryan (n 13) 519.
[87] Hafemeister and Payne Bryan (n 13) 526.

The courts have reinforced this position in the medical context. For example, the Supreme Court in *Cobbs* v *Grant*[88] found that 'the patient, being unlearned in medical sciences, has an abject dependence upon and trust in [their] physician for the information upon which [the patient] relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions.'[89] Those elements of vulnerability, dependence, and trust are widely cited to trigger a fiduciary relationship between medical professionals and patients where the relationship is not accepted or assumed.[90]

Despite clear US jurisprudence on the issue, the Instruction is silent on the circumstances in which a fiduciary relationship may be imposed upon medical professionals in American detention centres. This omission does not mean that a fiduciary relationship cannot be imposed; US law on the fiduciary relationship continues to apply. In the case study of this thesis, this method for attaching the fiduciary relationship may be relevant, especially in, 1) emergencies and, 2) cases where peril is caused by a medical professional. Both are discussed below.

3.2.1. Emergency Situations

The courts have tended to look favourably upon efforts to establish the existence of an affirmative duty to treat in emergencies. For example, in *Roberts* v *Galen of Virginia, Inc.*,[91] the US Supreme Court found that in an emergency a medical professional is under a duty to provide medical care to stabilise the patient even if they do not provide subsequent treatment.[92] Similarly, in cases of unmistakable medical emergencies, even private hospitals cannot reject a person in need of emergency treatment.[93] In addition to this case law, in 1986 the US Congress enacted the Emergency

[88] *Cobbs* v *Grant* (1972) 502 P.2d 1.
[89] ibid 9.
[90] Thomas L. Hafemeister and Richard M. Gulbrandsen, 'The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that Are Not Medically Indicated' (2009) 39 *Seton Hall Law Review* 335, 370; Tamar Frankel, 'Fiduciary Law' (1983) 71 *California law Review* 795, 796. See also: Rodwin (n 12) 243.
[91] *Roberts* v *Galen of Virginia, Inc.* (1999) 525 U.S. 249, 119 S. Ct. 685, 142 L. Ed. 2d 648.
[92] ibid.
[93] *Wilmington General Hospital* v *Manlove* (1961) 174 A.2d 135.

Medical Treatment and Labour Act (EMTALA) to further affirm the duty and ensure that hospitals are not refusing to provide care in emergencies. EMTALA defines an emergency as:

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.[94]

In any event, an emergency must be distinguished from other less medically dire situations that do not trigger the same duties.[95] The difference lies in the gravity of the situation.[96]

The Instruction covers emergencies: it confirms that the BSCs, who according to the US Administration would not be in a fiduciary relationship with the detainees, would nonetheless be under a duty to provide medical assistance in emergencies. However, the Instruction purports to limit the BSCs involvement in any lifesaving procedures to cases when there is no other medical professional to undertake this role. This narrow approach is not supported by US law and hence, US courts could impose the fiduciary relationships in emergencies more broadly. Indeed, the precedents show that courts have been willing to take a broad approach to recognise the existence of a fiduciary relationship in emergencies.

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[94] 42 USC § 1395dd(e)(1).

[95] *Hurley* v *Eddingfield* (1901)156 Ind. 416, 59 N.E. 1058.

[96] A research conducted by Nadia Zuabi, Larry D. Weiss and Mark I. Langdorf reviewed 192 cases between 2002–2015 and classified them into 12 categories of emergency medical conditions (EMC): '1. Failure to screen for an EMC; 2. Failure to stabilize a patient with an EMC; 3. Inappropriate transfer of a patient with an EMC; 4. Failure to transfer a patient with an EMC; 5. Patient turned away for insurance or financial status; 6. Patient in active labour; 7. On-call physician refused to see patient with EMC; 8. Patient with EMC inappropriately discharged; 9. Hospital did not accept referral for transfer in of patient with EMC; 10. No specialist physician available upon patient with EMC arrival; 11. ED on ambulance diversion; 12. Hospital where patient presented had capacity to care for EMC but refused. See: Nadia Zuabi, Larry D. Weiss and Mark I. Langdorf, 'Emergency Medical Treatment and Labour Act (EMTALA) 2002-15: Review of Office of Inspector General Patient Dumping Settlements' (2016) 17 *Western Journal of Emergency Medicine* 246.

3.2.2. Peril Scenarios

Secondly, US law places an affirmative duty of care on the person who causes peril,[97] even if this peril was caused without that person's fault.[98] This is a general duty of care imposed on everyone and is not specific to cases between medical professionals and patients. As such, it is not clear whether the courts would be willing to attach a duty of care in scenarios where a fiduciary relationship does not already exist between the parties. However, cases involving medical professionals who have used their expertise to endanger their patient's life or health, need to be treated differently. Such cases are not too far removed from scenarios where medical professionals would be required to provide treatment following their own mistake or negligence. Indeed, once a medical professional undertakes to act, he or she is legally liable for any negligence that should arise in providing such assistance.[99] It may be argued that such scenarios do not transpire from a medical professional causing peril to their patient, however, the main difference is that in cases of, for example, medical negligence, the duty of care is already attached before the peril is created by the negligent treatment.

Because the issue has yet to be tried, it is unclear whether the courts would find that involvement in EITs fell within the test of having created peril for the detainees, and if so, in which specific circumstances. However, the significant power imbalance between the parties and the vulnerability of the patient in this context gives strong grounds for a belief that the courts would be likely to find a fiduciary relationship. In fact, in the case study, the power imbalance is glaring as the medical professionals exercise their power over the application of EITs that are intended to cause pain and suffering to the detainees and so directly (and deliberately) cause the peril to the detainees' health and lives. Hence, it may be argued that the creation of peril is within their direct control.

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[97] See for example: *Hardy* v *Brooks* (1961) 118 S.E.2d 492, 495-96; *Farwell* v *Keaton* (1976) 396 Mich. 281, 240 N.W.2d 217; *Trombley* v *Kolts* (1938) 29 Cal. App. 2d 699, 85 P.2d 541. Dan B. Dobbs, *The Law of Torts* (West Academic Publishing: St. Paul, MN, 2000) 856: 'The defendant who knows or should know that he has caused physical harm to the plaintiff, even if caused without fault, owes a duty of reasonable care to avoid further harm.'

[98] *Hardy* v *Brooks* (1961)118 S.E.2d 492.

[99] See for example: B. Sonny Bal, 'An Introduction to Medical Malpractice in the United States' (2009) 467 *Clinical Orthopaedics and Related Research* 339, 342.

If the medical professionals' involvement in EITs can be considered to cause peril, in some or all cases, depending on the kind of conduct undertaken, this would open the door to finding a fiduciary relationship in a broad range of scenarios. Again, the Instruction does not comment upon this scenario. Indeed, the US Administration has consistently claimed that medical professionals were in American detention centres to do precisely the opposite of causing a peril, namely, in order to ensure that the EITs are 'safe, legal, and effective.'[100] However, as the SSCI report, discussed in Chapter One, conclusively demonstrates, the EITs were not safe, legal or effective and there was no evidence to substantiate the US Administration's claim.

The methods of attaching fiduciary relationships between medical professionals and patients, discussed above, have enabled courts to recognise the existence of the fiduciary relationship in a broad range of scenarios, moving away from cases where the fiduciary relationship is expressly accepted by medical professionals. While this thesis does not challenge the above-discussed law, it highlights that there might be an argument that there should be different considerations in cases of armed conflict or when discussing the use of EITs. Existing professional standards and medical duties are the same in conflict and peace scenarios.[101] However, it may be argued that medical professionals may hold higher duties given that we are potentially dealing with torture. The question would be whether it is possible and appropriate to transpose considerations of the fiduciary relationship when analysing these higher duties.

4. Limitations to the Fiduciary Relationship

While there are thus solid grounds for believing that a fiduciary relationship can be successfully established between medical professionals in the detention centres and detainees, it should be recognised that the fiduciary relationship is not unlimited in its scope and duration. US jurisprudence suggests several restricting factors that require some attention here, especially as these limitations do

[100] Jay S. Bybee, 'Memorandum to Alberto R. Gonzales' (2002); John C. Yoo, 'Memorandum to William J. Haynes, Application of Treaties and Laws to Al Qaeda and Taliban Detainees' (9 January 2002).
[101] See: The American Medical Association (AMA) Code of Medical Ethics.

not readily apply to those suggested within the Instruction. Those limitations, which are discussed in the following section, will become relevant in the context of the specific case study of the American detention centres, which is considered in detail in Chapter Four.

4.1. Limitations in the Circumstances

Applying US jurisprudence, the doctor-patient fiduciary relationship is limited to cases where the parties have had in-person contact. Conversely, 'the physician-patient relationship typically does not exist between the patient and those physicians who are consulted by the patient's personal physician.'[102] This means that even if the diagnosis or treatment recommended by medical professionals is the same in both cases, medical professionals who have seen the patient face-to-face would be in a doctor-patient relationship, while medical professionals reviewing patients' medical records and advising another doctor upon them, would not. This jurisprudence may be reflected in the Instruction especially in sections where it confirms that medical professionals treating patients are in a doctor-patient fiduciary relationship while medical professionals advising the BSCs on medical aspects pertaining to the detainees are not.[103]

However, such an approach fails to consider the fact that medical professionals who are giving the advice may have a significant influence concerning the choice of treatment, even if they do not have face-to-face contact with the patient. Indeed, in the case study of this thesis, some medical professionals who alter existing EITs, develop new ones (stage three of the taxonomy set out in the Chapter One) or tailor them to detainees' vulnerabilities (stage seven) have a profound effect on the detainees' health and life even without ever having to have face-to-face to contact with them. Further, US case law itself also suggests a different way of analysing how such cases should be approached

[102] David W. Louisell and Harold Williams, *Medical Malpractice. Volume 1* (Matthew Bender, 1970) § 8.03[2][a], 8-19 - 8-22; *Irvin* v *Smith* (2001) 31 P3d 934, 941 16; *Reynolds* v *Decatur Mem'l Hosp*. (1996) 660 NE2d 235, 238-39; *Oliver* v *Brock* (1976) 342 So 2d 1, 4.
[103] Instruction (n 66) 1.3.

(where medical professionals are advising on diagnosis and treatment without face-to-face contact). This different approach addresses the changing nature of the provision of medical services, which significantly rely on obtaining medical advice from other experts who do not have any patient contact.

The court in *Kelley* v *Middle Tennessee Emergency Physicians* found that 'the physician-patient relationship may be implied when a physician affirmatively undertakes to diagnose and/or treat a person, or affirmatively participates in such diagnosis and/or treatment',[104] even if such affirmative acts are made based on medical records only. In addition, in *St. John* v *Pope* the court found that although 'the fact that a physician does not deal directly with a patient does not necessarily preclude the existence of a physician-patient relationship.'[105] This means that a medical professional who makes a diagnosis and proposes treatment based on medical records in isolation can still be in a fiduciary relationship with the patient and so be subject to duties flowing from such a relationship.[106] This position is developing and differs between states. Nonetheless, these cases can offer a basis for arguing that medical professionals in American detention centres, who make a diagnosis and propose treatment determinations or recommendations, even without having any face-to-face contact with the detainees, can hold fiduciary duties towards them. If this argument is accepted, then if medical professionals were to alter the existing EITs, develop new EITs or tailor them, a fiduciary relationship could be imposed. This would further mean that even though the Instruction suggests otherwise, the ordinary medical professional assisting the BSCs, or the BSCs preparing EITs based on detainees' medical records could find themselves within the ambits of this jurisprudence. The rationale for adopting this approach here would be that medical professionals in American detention centres take important decisions affecting the detainees' health and wellbeing and should be accountable for such decisions. This is of particular importance where medical professionals make the ultimate decisions over the care afforded to patients or significantly influence their treatment.

[104] *Kelley* v *Middle Tennessee Emergency Physicians* (2004) 133 S.W.3d 587.
[105] *St. John* v *Pope* (1995) 901 SW2d 420, 424; *McKinney* v *Schlatter* (1997) 692 NE2d 1045, 1050-51, 2.
[106] *Kelley* v *Middle Tennessee Emergency Physicians* (2004) 133 S.W.3d 587; *Raptis-Smith* v *St. Joseph's Med. Ctr*. (2003) 302 A.D.2d 246, 755 N.Y.S.2d 384, 386; *Peterson* v *St. Cloud Hosp*. (1990) 460 N.W.2d 635, 638.

To prevent this jurisprudence from expanding indefinitely, the court in *Mead* v *Adler* set some limitations. It differentiated between the case of so-called 'curbside consultants', namely, medical professionals who evaluate a patient as a professional courtesy for another professional or a third party.[107] The court held that in cases of 'curbside consultants', no fiduciary relationship would be established. At the heart of the case were issues of the degree of power afforded to the consultant and the underlying intent. 'Curbside consultants' would not have ultimate power over the treatment offered and the medical professional would intend to advise and not make an ultimate decision in that regard.[108] This may suggest that in cases where medical professionals who alter, develop or tailor EITs would highly likely find themselves within the purview of a fiduciary relationship.

Moreover, the impact of advice provided by 'curbside consultants' on the medical professional who is personally responsible for a patient's treatment should not be underestimated. Indeed, the advice provided by a 'curbside consultant' may be adopted by the attending medical professional, be it as an affirmation of the treatment that he or she intended to offer or as an alternative to it. For this reason, it would appear unreasonable to protect the 'curbside consultant' from any accountability as his or her advice may have severe consequences for the patient. Indeed, courts are increasingly willing to recognise this.[109] For example, in *Diggs* v *Arizona Cardiologists, Ltd*., the court held that a cardiologist acting as a 'curbside consultant', could be found to have a duty of care towards patients.[110] The deciding factor was whether the 'curbside consultant' could reasonably foresee that the treating doctor would rely on his advice. In that case, the treating doctor 'did not exercise independent judgment as to… diagnosis; rather he subordinated his professional judgment to that of

[107] *Mead* v *Adler* (2009) 231 Or App 451, 220 P3d 118; *Reynolds* v *Decatur Memorial Hospital* (1996) 660 N.E.2d 235, 239. Michael Lin, Stephen C. Pappas, Joseph Sellin, *et al*., 'Curbside Consultations: The Good, the Bad, and the Ugly' (2016) 14 *Clinical Gastroenterology and Hepatology* 2. 'A curbside consultation must be (1) an informal process, (2) occurring between 2 physicians and involving a consultant, (3) who does not already have a pre-existing patient–physician relationship with the patient in question and is not covering for a physician who does. (4) The consultation cannot involve an on-call consultant or the care of a patient in the emergency room. (5) Furthermore, the consultant should not have any contact with the patient in question. The consultation (6) cannot result in a formal report, and (7) generally does not result in a charge or payment.' ibid 3.

[108] *Lownsbury* v *Van Buren* (2002) 762 NE2d 354; *State* v *Herendeen et al*. (2005) 279 Ga 323, 613 SE2d 647. Elizabeth Klumpp *et al*, 'Curbside Consultants' (2010) 7 *Psychiatry (Edgemont)* 51.

[109] See: *Diggs* v *Arizona Cardiologists, Ltd*. (2000) 8 P.3d 386; *Cogswell* v *Chapman* (1998) 672 N.Y.S.2d 460; *Campbell* v *Haber* (2000) 710 N.Y.S.2d 495.

[110] *Diggs* v *Arizona Cardiologists, Ltd*. (2000) 8 P.3d 386.

the specialist in cardiology.'[111] The issue of reliance on medical professional advice is of relevance to cases involving medical professionals in American detention centres precisely because they would sometimes be asked to provide advice on the vulnerabilities of their patients. However, even where medical professionals are asked to alter the existing EITs or develop new EITs, it is reasonable for them to expect that the CIA interrogators or other medical professionals would rely on their altered or developed EITs. This is considered in detail in the next chapter.

4.2. Limitation of the Duration

Apart from the limitation of circumstances, the fiduciary relationship can also be limited in its duration. The fiduciary duty would ordinarily be discharged once the medical professional satisfies the patient's treatment needs or hands over care to another medical professional.[112] The issue of the duration of the doctor-patient fiduciary relationship is indirectly addressed in the Instruction only once, where the Instruction establishes a three year 'limitation period' before medical professionals who used to provide medical care to the detainees can undertake any interrogation related duties. Considering that detainees are held in American detention centres for a prolonged period, it is still possible that, even with the imposed limitation, a medical professional after three years of abstaining from patient care, can become involved in EITs on a detainee who they had formerly treated. This situation would raise the question as to whether they are permitted to exploit the knowledge they gained during this previous relationship to the detriment of the detainees: would that be in breach of their fiduciary duty towards the detainees or, rather, would it be the case that by then the duty previously owed would have ceased to exist?

In *Clanton* v *Von Haam*, the court found that if subsequent dealings refer to unrelated matters, a previously established fiduciary duty would not be reattached.[113] Similarly, in *Haley* v *Medical Disciplinary Bd.*, a case concerning sexual contact between a medical professional and a patient, the

[111] ibid 27.
[112] Hall *et al.* (n 11) 127; *Payton* v *Weaver* (1982) 131 Cal.App.3d 38; *Ricks* v *Budge* (1937) 91 Utah 307, 64 P.2d 208.
[113] *Clanton* v *Von Haam* (1986) 177 Ga. App. 694, 340 S.E.2d 627.

court affirmed that the state medical board could take disciplinary action for breach of the fiduciary relationship where a sexual relationship occurred months after treatment.[114] Here, the court took a very broad approach in recognising the existence of a fiduciary relationship even after the treatment ceased. However, in certain cases, there may be a legitimate reason to acknowledge the existence of a continuing duty. Notably, where medical professionals in American detention centres have previously provided medical care to the detainees, it may be argued that in some cases, it would be difficult if not impossible, for them not to abuse detainee-specific medical knowledge in subsequent EIT-related activities. However, here, one would need to distinguish *Clanton* on the basis that medical professional in the case study would not be dealing with 'unrelated matters.'[115] If this argument is accepted, then the fiduciary relationship should also be found to operate continuously, meaning that medical professionals could not act contrary to these fiduciary duties (and for example, use the private medical data obtained in treating a patient to later abuse it in advising upon EITs).

5. Conclusion

This chapter has set out how a fiduciary relationship can be established or imposed under US domestic law, and the circumstances under which it would persist. It has sketched out some of the ways in which medical professionals operating in detention centres may be found to owe a duty of care to detainees, laying the groundwork for a more detailed analysis to be conducted in the next chapter. As the chapter argues, a fiduciary relationship is vitally important because it imposes an additional level of accountability on medical professionals with which others (for example, soldiers or civilians) are not burdened. This is particularly important in a context where it has proven challenging to hold doctors accountable through other mechanisms. The above analysis suggests that addressing the medical professional's involvement in EITs through recognising the fiduciary relationship provides for an additional (moreover, because of the procedural or evidential thresholds, often the only) legal

[114] *Haley* v *Medical Disciplinary Bd.*, (1991) 818 P.2d 1062.
[115] ibid.

avenue to hold the doctor accountable for wrongdoing (independently of the nature of the wrongdoing).

The chapter identifies the applicable laws and places the Instruction within them. As it is clear from the legal standards discussed in this chapter, the Instruction does not reflect the true scope of US law on this issue and so creates the impression that medical professionals would not be subject to a fiduciary relationship with detainees, whereas the law suggests otherwise. Indeed, the Instruction portrays only a limited number of scenarios where a fiduciary relationship may be attached, namely where the medical professional accepts or assumes the fiduciary relationship, and ignores that the fiduciary relationship could be attached in other cases. It has also highlighted some of the points on which the Instruction gives a false or misleading impression on these issues. It is important to emphasise again that the Instruction, being a guidance document,[116] operates only within the ambits of the existing law and does not have the power to change it. The failure to provide accurate, adequate and comprehensive guidance in the Instruction cannot be seen as to affect the accountability of medical professionals as they are expected to know the law that applies to them concerning their medical duties and, specifically, in which scenarios the fiduciary duty attaches. However, the question would be whether they could assume that the guidance they are given reflected the law. Could they reasonably rely on it? This issue is discussed in Chapter Four. Considering the Instruction's shortcomings in presenting the applicable law, it is crucial to explore the nature of the relationship between medical professionals in American detention centres and detainees, considering the different involvements that they may have had in EITs. This is the role of the next chapter.

[116] See: Chapter Two, Section 4.

CHAPTER FOUR: Putting the US Administration's Arguments to the Test: The Fiduciary Relationship

1. Introduction

The previous chapter argued that the US Administration's attempt to preclude the existence of a fiduciary relationship between medical professionals and detainees, preventing them from being held accountable for their involvement in EITs, is misconceived. Specifically, it argued that the US Administration's guidelines do not accurately reflect US law on the fiduciary relationship between medical professionals and detainees as patients. According to US jurisprudence, while this relationship is often accepted or assumed by medical professionals, it can also be imposed by the courts in circumstances that justify so doing. Notwithstanding the Instruction, in determining when a fiduciary relationship may be attached and on what basis, each case must be considered on its merits. Nonetheless, the existence of the Instruction (and the US Administration's legal opinions pertaining to the EITs, as discussed in Chapter Two[1]) may have an effect on the accountability of medical professionals despite its flawed legal reasoning. Medical professionals may be able to claim a good faith defence,[2] in that they relied on the legal opinion in circumstances where they did not know and could not have known that it was flawed.[3]

This chapter tests the US Administration's denial of the existence of a fiduciary relationship between medical professionals and detainees against the legal framework set up in the previous chapter. It argues that the Instruction departs from US law, and that, in accordance with US law, the fiduciary relationship can be established or imposed on different types of medical professionals in American detention centres. This chapter then proposes how the fiduciary relationship can be attached to the different types of medical professionals, with a specific focus on cases where the courts can impose the fiduciary relationship in all circumstances. Here, the chapter also considers cases where the

[1] Chapter Two, Section 2.
[2] See: Section 1404(a) of the Detainee Treatment Act of 2005, Public Law 163-109, 119 Stat. 3136, 6 January 2006.
[3] See Section 3 below.

fiduciary relationship could not be attached. First, this chapter discusses the nature of the relationship between medical professionals and detainees (Section 2). Second, it further considers the question of good faith reliance: Could medical professionals have relied on this legal opinion in good faith?[4] Is this reliance reasonable where the legal opinion was widely and openly challenged by legal experts and activists, even from those inside of the US Administration?[5] Understandably, there is a difference between erring in law[6] and being given a legal opinion (from a legitimate and authoritative body) that introduces the issue and presents it as applicable law.[7] As such, the chapter responds to the question of whether medical professionals could have a legitimate expectation that they were not in a fiduciary relationship with detainees based on the assurances given by the US Administration (Section 3).

2. The Nature of the Relationship between Medical Professionals and Detainees

Chapter Three explained how the nature of the relationship between a doctor and patient is of importance to the duties between them, with a fiduciary relationship imposing the highest standard of conduct that can be imposed by law.[8] For that reason, establishing a fiduciary relationship between medical professionals and detainees in American detention centres may assist with holding them to account for their involvement in administering EITs. The below section discusses the nature of this relationship in the context of the case study. The following analysis takes into consideration two variables, first, the type of medical professionals (distinguishing between ordinary medical professionals, Behavioural Science Consultants (BSCs), and ordinary medical professionals assisting

[4] US Attorney General Eric Holder when releasing the legal memos states that 'In releasing these memos, it is our intention to assure those who carried out their duties relying in good faith upon legal advice from the Department of Justice that they will not be subject to prosecution.' See: Barack Obama, 'Statement on Release of OLC Memos' (16 April 2009).
[5] See for example, William Taft IV, 'Memorandum to John Yoo, Re: Yoo Draft Memorandum of January 9, 2002' (11 January 2002).
[6] See Section 4.4.
[7] Claire O. Finkelstein and Michael Lewis, 'Should Bush Administration Lawyers Be Prosecuted for Authorising Torture?' (2010) *University of Pennsylvania Law Review* 223. 'By definition, any mistake that a lawyer makes in describing the law to a client will be a mistake of law rather than a mistake of fact… if a client acts on mistaken advice from a government lawyer acting within her area of competence, then the lawyer is criminally liable as an accomplice.' Jose E. Alvarez, 'Torturing the Law' (2006) 37 *Case Western Reserve Journal of International Law* 175, 208. 'Principals who mistakenly believe that their actions are lawful are out of luck; mistake of law simply is not relevant for their *mens rea*.'
[8] Nicolas P. Terry, 'Physicians and Patients Who "Friend" and "Tweet" Constructing a Legal Framework for Social Networking in a Highly Regulated Domain' (2010) 43 *Indiana Law Review* 285, 304.

the BSCs, as per the categorisation established by the US Administration), and second, the different levels of involvement in EITs (as set out in the taxonomy developed in Chapter One).

On the basis of the evidence discussed in Chapter One, and contrary to what the US Administration has claimed, the analysis proceeds on the basis that all medical professionals in American detention may have been involved in all stages of the taxonomy. Nonetheless, the analysis below is structured around the roles undertaken by medical professionals in American detention centres, because the US Administration treats them differently and as such, they are said to be in a different kind of relationship with detainees based on the role they perform.

The analysis is necessarily speculative given that much of what happens in detention centres remains unknown. As such, this section also explains the kinds of considerations that courts would take into account in determining whether the relevant test was met. While there are arguments on both sides, the analysis will show that the better view is that a fiduciary relationship should be imposed. Understandably, this is to some extent speculation. While there may be problems imposing the fiduciary relationship, there are good reasons – both legal and policy – for arguing that it should be recognised, putting forward a strong argument that this is what the courts should be doing.

2.1. The Ordinary Medical Professionals

The most straightforward cases where a fiduciary relationship is established is that of the ordinary medical professionals providing basic medical care to the detainees (stage one of the taxonomy). The Instruction reveals that ordinary medical professionals would have been involved in the provision of basic medical care as primary carers for detainees.[9] When providing basic medical care, the doctor-patient fiduciary relationship is generally established by the medical professional agreeing to provide medical care to the detainee.[10] While there may be some deviations from case to case, the fiduciary

[9] This is as per the US Department of Defence Instruction. Although, a more active involvement of the BSCs cannot be excluded. US Department of Defence, 'Instruction 2310.08E, Medical Program support for detainee operations' (6 June 2006).
[10] See Chapter Three, Section 3.1.

relationship would resemble similar relationships in other closed institutions, such as ordinary prisons.[11] As explored in Chapter Two, the Instruction does not suggest anything to the contrary.

Once the medical professional has accepted the fiduciary duty of care for the detainee (as a patient) and the fiduciary relationship is thus established, the fiduciary relationship determines all aspects of the relationship between the medical professionals and the detainees,[12] with fiduciary duties also owed when doctors engage in the remaining stages of the taxonomy, (unless this duty is discharged before the other activities are undertaken and is not reattached as discussed in Chapter Three[13]). This applies to the monitoring of the use of EITs (stage two); developing new and altering existing EITs (stage three); abusing detainees' medical data for EITs (stage four); falsifying evidence of the use of EITs (stage five); treating injuries to facilitate further use of EITs (stage six); advising on and tailoring EITs to a detainee (stage seven); force-feeding the detainees (stage eight); withdrawing or withholding basic medical care from the detainees (stage nine), and directly participating in EITs (stage ten).

Once subject to a fiduciary relationship, ordinary medical professionals would have been required to act in the best interest of the detainees.[14] To do so, they would have had to abstain from any activities that may facilitate crimes or other unlawful or unethical treatment,[15] such as, for example, unnecessary medical procedures. Apart from acting in the best interest of the patients, other

[11] Victor W. Sidel and Barry S. Levy, 'Physician-Soldier: A Moral Dilemma' in Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 296.
[12] Gregg M. Bloche, 'Clinical Loyalties and the Social Purposes of Medicine' (1999) 281 *Journal of the American Medical Association* 268; Marc A. Rodwin, 'Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System' (1995) 21 *American Journal of Law and Medicine* 243; Paul D. Finn, 'The Fiduciary Principle' in Timothy G. Youdan (ed.), *Equity, Fiduciaries and Trusts* (Carswell: Toronto, 1989) 33; Mark Rodwin, *Medicine, Money and Morals: Physician's Conflict of Interest* (Oxford University Press: New York, 1993).
[13] See Section 3.3. (above). Furthermore, in *Houghton* v *West* (1957) 305 S.W.2d 407, 411-12, the court found that the medical professionals owed the fiduciary duties that carried into the parties' dealings outside of the medical treatment.
[14] Howard Brody, *The Healer's Power* (Yale University Press: New Haven, 1992) 64; Peter Bartlett, 'Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship' (1997) 5 *Medical Law Review* 193, 197; Paul Sieghart, 'Professional Ethics - For whose Benefit' (1982) 8 *Journal of Medical Ethics* 25, 26; Bloche (n 12) 268.
[15] 'Duty of utmost good faith, trust, confidence, and candour owed by a fiduciary . . . to the beneficiary; a duty to act with the highest degree of honesty and loyalty toward another person and in the best interests of the other person,' cited in Thomas L. Hafemeister and Richard M. Gulbrandsen, 'The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that Are Not Medically Indicated' (2009) 39 *Seton Hall Law Review* 335, 368; Bryan A. Garner, *Black's Law Dictionary* (Thomson-West Publishing Company, 2004) 303.

performance-oriented duties would also need to be observed, for example, the duty of loyalty,[16] acting in good faith,[17] and confidentiality.[18] As ordinary medical professionals are to comply with these duties, especially the duty to act in the patient's best interest, they may find themselves in a situation where they might not be able to provide medical care to detainees where it would facilitate further EITs. This conflict is discussed in Chapters Five and Six which explore how these duties could be discharged.

The picture is more complex where an ordinary medical professional did not provide basic medical care to a specific detainee, thus failing to establish a fiduciary relationship as per stage one, but engaged in other kinds of conduct set out in the taxonomy. In those cases, a fiduciary relationship may still be established depending on whether the degree of contact is sufficient for the fiduciary relationship to be attached in line with the jurisprudence discussed in Chapter Three. The below argues that the fiduciary relationship could be assumed in some cases where the ordinary medical professional undertakes affirmative actions or where it is imposed in all circumstances.

In cases where ordinary medical professionals monitored EITs (stage two), it is very unlikely that a fiduciary relationship is established. It may not be possible to show either that they accepted a fiduciary relationship (unless there is evidence to the contrary) or assumed one by way of undertaking affirmative steps concerning the treatment of the detainees. However, even in this case, the courts may impose the fiduciary relationship in these circumstances. As Chapter Three shows, the courts are prepared to impose the fiduciary relationship to address the imbalance of power and would thus attach weight to the vulnerable position of the detainee.[19] There are two aspects to the power imbalance in this context. First, the ordinary medical professionals that monitored the EITs possess knowledge of them and their effects on the detainees which, presumably, is not available to any other medical

[16] *Woolley* v *Henderson* (1980) 418 A.2d 1123, 1128 n.3.
[17] *Taber* v *Riordan* (1980) 403 N.E.2d 1349, 1353.
[18] *Mull* v *String* (1984) 448 So. 2d 952, 953: 'Alabama recognises a cause of action for breach of fiduciary duty... resulting from a physician's *unauthorised disclosure* of information acquired during the physician-patient relationship.'
[19] See: Chapter Three, Section 3.2. and *Cobbs* v *Grant.*

professionals. Second, if the use of EITs were not recorded and there is no other evidence of the abuse suffered by the detainees, the abuse may go undiscovered, or its discovery will be delayed (for example, until the detainee is examined by medical professionals). These arguments would naturally flow from courts' existing jurisprudence that aims to protect the vulnerable party.[20] However, imposing a fiduciary relationship here may be excessive if the ordinary medical professionals do not engage in any other way than merely monitoring the EITs. This would then open the gates to an argument that all medical professionals in American detention centres who know about the use of the EITs (which would presumably be all or most of them) could fall within the purview of the fiduciary relationship. This would be contrary to the established jurisprudence that says that the fiduciary relationship can be established where medical professionals accept or assume fiduciary duties or where it is imposed in all circumstances. However, considering the consequences of each type of involvement and what is at stake, there may be legitimate reasons to do so.[21]

The determining factor may be the purpose of the monitoring conducted, the existence of a fiduciary relationship in this context may turn on a close examination of the available evidence. Are they monitoring to collect detainees' medical data about the EITs used and their effects? Are they monitoring to provide emergency care to the detainees? Or is their role a hybrid of these two? According to the US Administration, ordinary medical professionals were in detention centres, not to monitor EITs but to provide medical care only. If contrary to what the US Administration claims, ordinary medical professionals have been monitoring EITs to provide medical care, a fiduciary relationship is highly likely to exist. Similarly, if they undertake a hybrid role, the fiduciary relationship would be attached. In those cases where they monitor the interrogation to collect medical data only, this may not be enough to trigger a fiduciary relationship. However, it may be possible to

[20] *Hoopes* v *Hammargren* (1986) 725 P.2d 238, 242.
[21] Furthermore, even if the fiduciary relationship cannot be imposed, medical professionals would be under certain duties, for example, to report abuse.

establish one in cases where medical professionals were monitoring EITs to collect medical data from the detainees that they were responsible for.

Stage three of the taxonomy, where medical professionals use their expertise to advise on developing new or altering existing EITs, without any contact with the detainees, may be another case where it would be difficult to attach a fiduciary relationship. It is unlikely here that the ordinary medical professionals would have had accepted fiduciary duties towards detainees. Advising on EITs, in general, may lie outside of the scope of conduct identified by the court in *Mead* v *Adler*, a case where medical professionals were held to have assumed a duty of care by way of their affirmative actions concerning the care of the patient.[22] While not prescribing an exhaustive list, the court detailed a range of aspects of doctor-patient care, for example, 'examining, diagnosing, treating, or agreeing to do so',[23] which are very different from the current scenario. As stage three of the taxonomy does not involve any such conduct, it is unlikely that the courts would find that a fiduciary relationship had been triggered in line with *Mead* v *Adler*.

Following current US domestic law, under stage three, the medical professionals, at most, would be treated as 'curbside consultants.'[24] As discussed in Chapter Three, 'curbside consultants' are professionals who provide medical advice 'for the benefit of a third party or as a professional courtesy for [another professional].'[25] Since 'curbside consultants' do not have any doctor-patient contact, access to the patients' full medical history or power over the treatment ultimately afforded to the patient, they are outside of the traditional scope of the fiduciary relationship. However, as Chapter Three has shown, US courts are increasingly recognising the existence of the fiduciary relationship in such cases, acknowledging that their medical advice may have a profound effect on the treatment provided to the patient, even without face-to-face contact.

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[22] ibid 458.
[23] Stephen C. Bush, 'Formation of the Physician-Patient Relationship: The Oregon Court of Appeals Clarifies, but Questions Remain.' (2010) 13 *Physician Organizations* 11.
[24] *Mead* v *Adler* (2009) 231 Or App 451, 220 P3d 118; *Reynolds* v *Decatur Memorial Hospital* (1996) 660 N.E.2d 235, 239. See also: Chapter Three, Section 3.2.1.
[25] ibid.

Here, it may be further argued that the medical professional who provided generic advice on EITs are even further removed from a fiduciary relationship than a 'curbside consultant' as they did not provide advice concerning a specific patient. A 'curbside consultant' would have been asked to provide advice on the treatment of an identifiable patient. Their activities under stage three are limited to altering the existing or introducing new EITs, without a particular detainee in mind.

Yet, it might be argued that medical professionals who use their expertise to develop new or alter existing EITs assumed a duty towards the detainees by way of designing the EITs in the full knowledge that they became more effective (e.g., intensifying the pain but reducing its duration) and so prevented long-term health problems or death. As such, it may be argued that a medical professional accepts a duty of care by acting in the best interest of detainees, subject to considerations of foreseeability and remoteness. While these activities are unlikely to be directed towards a particular detainee, under US law a duty of care is owed to all foreseeable victims (claimants) under two doctrines, the 'zone of danger' doctrine, also known as the Cardozo view, and the Andrews view, deriving from the minority opinion opposing Justice Cardozo. Both of these doctrines stemmed from *Palsgraf* v *Long Island Railroad.*[26] Under the Cardozo view, a plaintiff can recover if she was located within the zone of danger created by the negligent conduct. Cardozo's zone of danger doctrine states that:

> One who seeks redress at law does not make out a cause of action by showing without more that there has been damage to his person. If the harm is not wilful, he must show that the act as to him has possibilities of danger so many and apparent as to entitle him to be protected against the doing of it though the harm was unintended.[27]

Conversely, in the minority opinion of Justice Andrews, every victim is foreseeable:

[26] *Palsgraf* v *Long Island Railroad Company* (1928) 248 N.Y. 339, 162 N.E. 99.
[27] ibid.

> Where there is an unreasonable act, and some right that may be affected there is negligence whether damage does or does not result. (…) Should we drive down Broadway at a reckless speed, we are negligent whether we strike an approaching car or miss by an inch. The act is itself wrongful. It is a wrong not only to those who happen to be within the radius of danger but to all who might have been there--a wrong to the public at large.[28]

While Andrews' view may be considered excessively broad, the underlying principle of being responsible for one's wrongful action may be aligned with medical professional norms and the fiduciary relationship itself. Detainees in American detention centres meet the broader Andrews' view and also Cardozo's 'zone of danger' test. While the group of potential victims is large, possibly as wide as all detainees held in American detention centres pursuant to the War on Terror, the group of victims is easily identifiable, thus falling within the 'zone of danger.'[29] It may be argued that considering that we are dealing with a foreseeable (and identifiable group), namely detainees in American detention centres, the issue of remoteness would not manifest. This also depends on whether EITs were to be used on those who are detained at a later date or those who are already detained.

However, while medical professionals altering the existing or developing new EITs may hold some duties towards the detainees by virtue of their conduct, putting detainees' lives and health at risk, this does not necessarily manifest in a fiduciary relationship. Indeed, as discussed in Chapter Three, there is a difference between a general duty of care and a fiduciary duty. The fiduciary duty, contrary to the general duty of care, imposes a higher obligation on the duty holder.

Finally, the question would be whether a fiduciary relationship may be imposed. There are a few challenges that must be considered here. First, it is questionable whether the test of 'creating a peril'

[28] ibid.
[29] *Trombley* v *Kolts* (1983) 29 Cal. App. 2d 699 [85 P.2d 541]; *Hardy* v *Brooks* (1961) 103 Ga. App. 124, 126.

is met. The peril is caused by the use of EITs in general, and they would, highly likely if not certainly, be used on detainees even without the involvement of medical professionals. Although the contribution of medical professionals involved in the process cannot be ignored, a distinction should be made between the development of new and the altering of existing EITs as they require different considerations. Developing new EITs would likely be found to amount to 'creating a peril' as it would meet the 'but for' test:[30] but for the medical professional's advice, the new EITs would not have been created. The considerations are different in the case of altering existing EITs as here the peril would exist regardless of the medical professional's contribution in altering them. The 'but for' test will not be satisfied if the injury would have occurred regardless of the acts of the medical professional.[31] While it is possible that other actors could develop new EITs, that does not undermine the argument that medical professionals should be responsible for the EITs they have in fact developed. Furthermore, it is unlikely that the same or even similar EITs could be developed by others who do not have the same medical expertise and understanding of the human body and susceptibility to pain. In the case of altering pre-existing EITs the 'but for' test may not be satisfied if the alterations do not change EITs significantly.[32]

Conversely, interpreting an altered technique devised by medical professionals as a peril is problematic. The question is what altering existing EITs actually means. There are conflicting opinions about the impact of different EITs used on the detainees,[33] which will ultimately affect the question of liability. Do altered EITs cause more pain and suffering to the detainees or do they make EITs safer or shorter in duration? Is the medical input on EITs contributing to the peril or alleviating

[30] William L. Prosser, *Handbook of the Law of Torts* (West Publishing Company: St. Paul MN, 1971) § 41.
[31] ibid.
[32] Ralph Nader, 'The Corporate Drive to Restrict Their Victims' Rights' (1986) 22 *Gonzaga Law Review* 15, 16; *Anderson* v *Minneapolis, St. Paul & Sault Ste. Marie Railway* (1920) 179 N.W. 45, 46-47. Nonetheless, in certain states, the requirement of causation may be relaxed. See: Hafemeister and Payne Bryan (n 388) 524.
[33] Brian Ross, Matthew Cole and Joseph Rhee, 'The CIA's $1000 a Day Specialists on Waterboarding, Interrogations' *ABC News* (30 April 2009); Helen Mooney, 'US Doctors were Complicit in Guantánamo Bay Torture, Report Says' (2011) *British Medical Journal* 342; Lisa Hajjar, 'Does Torture Work? A Sociolegal Assessment of the Practice in Historical and Global Perspective' (2009) 5 *Annual Review of Law and Social Science* 311; Farnoosh Hashemian *et al*., 'Broken Laws, Broken Lives: Medical Evidence of Torture by the US Personnel and Its Impact' (Physicians for Human Rights, 2008). See also: Chapter One, Section 2.4.

or neutralising it? The US Administration claims that medical professionals' contribution to EITs made them more effective and reduced the time that detainees' were exposed to them, albeit intensifying the pain.[34] The question then is whether shorter but more painful, or longer but less painful exposure to EITs would constitute an exacerbation or alleviation of the peril. The answer is likely to be case-sensitive. This introduces a significant evidentiary burden in assessing such cases. As discussed in Chapter Two, altering EITs was intended to increase pain and ensure the effectiveness of the interrogation. If the alterations transformed the EITs so that they became more effective, or significantly more effective, there may still be room to argue that 'but for' the doctor's contribution, this specific peril would not have existed. Given that the purpose of altering the EITs was to cause more pain and suffering to extract the information from the detainees quicker, it is likely that the courts would find that peril is created or exacerbated, and impose a fiduciary relationship. In light of the existing jurisprudence, the courts are likely to find the existence of the fiduciary relationship, but this will depend on the doctors' acts, the extent of their contribution and all of the circumstances.

The conduct covered in the subsequent stages of the taxonomy offers a better chance of attracting a fiduciary relationship, even where the ordinary medical professional is not providing basic medical care. Where doctors misuse detainees' medical data for EITs (stage four), ordinary medical professionals would likely have been in the fiduciary relationship as otherwise they would not have been tasked with producing and handling the detainees' medical records. Understandably, medical professionals could be asked to look over a patient's records to glean information for other reasons, for example, where accessing the medical data could fall within one of the exceptions for when data can be accessed by others.[35] Such scenarios are regulated by law and this does not give a *carte blanche*. Furthermore, when providing medical professionals with access to detainees' medical data, there are legitimate reasons to attach a fiduciary relationship to protect detainees from their medical data being abused. Indeed, medical professionals are asked to extract data on the detainees'

[34] Steven G. Bradbury, 'Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques that May be Used in the Interrogation of a High-Value al Qaeda Detainee: Memorandum to John A Rizzo' (2005) 62.
[35] See Chapter Six, Section 2.3.

vulnerabilities that could be used for the EITs. This differs significantly from the ordinary exceptions to the privacy of medical data to, for example, protect others from the patient's medical conditions.[36]

Misusing a detainees' medical data for the purposes of EITs, stage four of the taxonomy, where a pre-existing fiduciary relationship does not exist, could be interpreted as creating a peril. This may establish grounds to impose a duty.[37] By disclosing medical data on a detainee's vulnerabilities, medical professionals expose the detainee to a higher risk of abuse by interrogators by way of tailored EITs. Without medical assistance, the interrogators would not have had access to the medical data and would not be able to analyse it in the same way that a medical professional could. It is unlikely that medical professionals would be considered a 'curbside consultant' and outside of the purview of the fiduciary relationship. First, contrary to the 'curbside consultants' doctrine, ordinary medical professionals have access to or possession of the detainees' medical data. Second, they disclose this data to others, who do not have a right to this data and are highly likely to abuse the detainee, with or without having first read and analysed the data themselves.

Where medical professionals falsify detainees' medical data (stage five), the fiduciary relationship likely pre-exists. Modifying medical data suggests that a duty to record medical data exists in the first place. Alternatively, by falsifying evidence of the use of EITs, ordinary medical professionals may have created a peril to the lives or health of the detainees. Injuries that detainees sustain were not adequately treated or abuse is concealed against their interests.[38] Because of the falsification, detainees may not receive the essential care and treatment (especially for injuries that are not obvious from superficial examination) and this would prolong their pain and suffering (which could cause long-term medical consequences). Further, some injuries may not have been recorded and the detainees' fitness for interrogation may not be re-assessed before further EITs begin. The detainee may be subject to further interrogation with an increased risk of injury. This situation is different from

[36] ibid.
[37] *Trombley* v *Kolts* (1938) 29 Cal. App. 2d 699 [85 P.2d 541].
[38] ibid.

typical cases of fraudulent concealment of patient information, for which significant jurisprudence exists.[39] Nonetheless, considering that the effect of falsifying and concealment of evidence may be similar in result, namely, that detainees would not receive the necessary treatment or receive incorrect treatment, the courts are likely to apply the jurisprudence by analogy. That is, to recognise medical professionals' accountability for medical data failures that affect the lives or health of the detainees.

Ordinary medical professionals who provide treatment of the detainees' injuries (stage six) would likely be found to owe a fiduciary relationship to detainees by way of accepting or assuming the duty of care (as with stage one), despite their purpose being to facilitate the further use of EITs. Further, even if this motivation were taken to preclude acceptance or assumption of a duty to act in the best interests of the detainees,[40] the fiduciary relationship could still be imposed in all circumstances, through providing treatment and certifying the detainees for further interrogations, the ordinary medical professionals expose their patient to peril, the risk of further EITs.

The ordinary medical professionals who advised on and tailored the EITs for a specific detainee (stage seven) may also be burdened with a fiduciary relationship. The main consideration for establishing the fiduciary relationship here would be whether medical professionals undertook any activities (in the best interest of the detainees) to assist the detainees and thereby accepted or assumed a duty of care.[41] While acceptance of the duty would be the most straightforward method of establishing a fiduciary relationship, that is very unlikely here, as the medical professionals are acting specifically to tailor the EITs to abuse the detainees' vulnerabilities. Nonetheless, where medical professionals tailor EITs, not merely to ensure their effectiveness, but also to minimise any long-term consequences to the life and health of the detainees, that can be construed as acting in the detainees' best interests.

[39] *Guy* v *Schuldt* (1956) 138 N.E.2d 891, 895; *Natanson* v *Kline* (1960) 350 P.2d 1093, 1101-02; *Billings v. Sisters of Mercy*, 389 P.2d 224, 228 (Idaho 1964).
[40] Louisell and Williams (n 469) § 8.03[2][a], 8-19 - 8-22; *Irvin* v *Smith* (2001) 31 P3d 934, 941 16; *Reynolds* v *Decatur Mem'l Hosp*. (1996) 660 NE2d 235, 238-39; *Oliver* v *Brock* (1976) 342 So 2d 1, 4; *Trombley* v *Kolts* (1938) 29 Cal. App. 2d 699 [85 P.2d 541]; *Hardy* v *Brooks* (1961) 103 Ga. App. 124, 126 (118 SE2d 492).
[41] See Chapter Three.

It might then be argued that they have accepted a duty of care towards detainees and so minimise the adverse consequences of the EITs. As such, *Mead* v *Adler* would be relevant here.[42]

Affirmative action involves taking 'action to participate in the care and treatment of a patient' or undertaking to diagnose or treat the patient.[43] The question that a court would need to determine is whether advising on and tailoring EITs to a detainee could be seen as an affirmative action. This may be the case where the advice aimed to decrease the pain and ensure the safety of the detainee. However, where the advice and tailoring of EITs are aimed at explaining a detainee's vulnerabilities to ensure that the detainee will cooperate quicker, it is unlikely that courts would consider that medical professionals have assumed fiduciary duties. Advising on or tailoring EITs to each detainee was intended to further exploitation of their vulnerabilities and to ensure their effectiveness; this was carried out in the interest of the state. However, a fiduciary relationship could be imposed here, analogous to stage three above, but with the notable exception that here advising and tailoring of the EITs is carried out upon a targeted detainee. Hence, the issues surrounding foreseeability and remoteness do not apply. The actions of medical professionals who advised on or tailored EITs should be distinguished from mere 'curbside consultants.'[44] Their involvement goes beyond mere second opinion and involves a level of control over the chosen EITs that 'curbside consultants' would not be able to achieve.[45] Hence, it is very likely that the courts would impose a fiduciary relationship in all the circumstances.

We know that detainees were also subjected to force-feeding (stage eight). Force-feeding is not an EIT approved and authorised by the US Administration, although this does not mean that it could not have been used. If force-feeding was carried out by ordinary medical professionals who provided basic medical care, then a fiduciary relationship will already be established. However, even if not,

[42] *Mead* v *Adler* (2009) 321 Or App 451, 458.
[43] ibid. See also: *Sterling* v *Johns Hopkins Hospital* (2002) 145 Md.App. 161, 187, 802 A.2d 440; Bush (n 390). See also: *Kelley* v *Middle Tennessee Emergency Physicians* (2004) 133 SW3d 587, 596.
[44] *Mead* v *Adler* (2009) 231 Or App 451, 220 P3d 118; *Reynolds* v *Decatur Memorial Hospital* (1996) 660 N.E.2d 235, 239.
[45] ibid. Also: *Lownsbury* v *Van Buren* (2002) 762 NE2d 354; *State* v *Herendeen et al* (2005) 279 Ga 323, 613 SE2d 647.

force-feeding may put them within the purview of a fiduciary relationship as they are accepting or assuming a fiduciary duty for detainees if they force-feed to save the life or health of the detainee. Here, even if there was no pre-existing fiduciary relationship, a fiduciary relationship could be established as forced feeding may constitute medical care, carried out in the best interests of the detainees.[46] If a fiduciary duty is not accepted or assumed, the courts would likely impose it. Medical professionals in this context are engaged in a medical procedure to preserve health and life, with all of the inherent risks of infection, pneumonia, collapsed lungs, and death that follow. Furthermore, force-feeding, in itself, may also constitute a peril, at least in some cases. For example, one of the detainees, Abu Wa'el Dhiad, offered a graphic account of his own force-feeding. He reports that he had:

> been dragged out of his cell, trussed up like an animal, secured tightly to what the detainees universally called "the torture chair," had a 110-centimetre tube shoved up his nose, force-fed in the chair, then had the tube pulled out, forced from the chair to the ground and then carried back to his cell, put face down on a cement floor, the restraints removed with guards straddling his injured back.[47]

Nonetheless, it is not currently possible to conclude, from the available evidence, how representative his experience is of more general practice in American detention centres.

Failure to provide treatment (stage nine), would not constitute a culpable breach *per se*, where a fiduciary relationship does not already exist, as the duty of care would have first to be established. However, depending on the situation, and especially in emergencies, the courts may consider that the medical professional does have a fiduciary relationship and must provide emergency assistance.[48]

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[46] This was recognised in *People ex rel. Dept. of Corrections* v *Fort* (2004) 352 Ill.App.3d 309, 314, 287 Ill.Dec. 443, 815 N.E.2d 1246 where the court considered force-feeding as a procedure aimed at, among others, the preservation of life and prevention of suicide. This is also confirmed in *Laurie* v *Senecal* (1995) 666 A.2d 806, 809 and *re Caulk* (1984) 125 N.H. 226, 231, 480 A.2d 93.

[47] Carol Rosenberg 'US Attorney Defends Guantánamo Hunger Striker's Forced-Feedings' *Miami Herald* (6 October 2014).

[48] ibid.

Indeed, as is clear from the case law discussed in Chapter Three, courts have imposed a fiduciary relationship between medical professionals and individuals in an emergency, even in private hospitals where the individuals were not patients.[49] Courts recognise that a 'frank - i.e. unmistakable emergency' triggers the imposition of a fiduciary relationship.[50] Each case would turn on its own facts. Here, apart from considering whether detainees are experiencing a frank and unmistakable medical emergency, another consideration is that they are in a closed institution, and if not provided with medical assistance, they do not have the option of seeking alternative treatment. Hence, it may be argued that the duty to treat would be much broader. Once the duty of care is attached, withholding or withdrawing medical care may be culpable.

Lastly, it is very unlikely that ordinary medical professionals who inflict pain and suffering by way of EITs (stage ten), accept or assume a fiduciary relationship, unless there is evidence to the contrary. For example, where it can be demonstrated that they implemented the EITs themselves to aid the safety of the procedure, etc. However, the fiduciary relationship is likely to be established by virtue of the creation of a peril to the life and health of the detainee. Here, the creation of the peril is most direct as it follows the infliction of the EIT. Considering that the ordinary medical professional uses their skills and expertise to administer EITs on detainees, there are legitimate reasons to attach the fiduciary relationship between them and detainees.

This section established that for ordinary medical professionals in almost all circumstances a fiduciary relationship will be found. Often this will be assumed or accepted, but in other cases where it is not possible to show that ordinary medical professionals accepted or assumed a fiduciary duty (stages four to ten), the courts will impose this because the medical professional has created a peril. In a small number of cases (stage two where they monitor the EITs, and stage three where they improve the existing or develop new EITs for an unascertainable group), no fiduciary relationship may be

[49] *Wilmington General Hospital* v *Manlove* (1961) 174 A.2d 135. See also: *O'Neill* v *Montefiore Hospital* (1960) 11 A.D.2d 132, 202 N.Y.S.2d 436.
[50] ibid.

owed, though this will turn on the facts and will depend whether the circumstances are such that imposing the fiduciary relationship would be justified.

2.2. The Ordinary Medical Professionals Assisting the Behavioural Science Consultants

According to the Instruction, ordinary medical professionals who were assisting the BSCs were not in a fiduciary relationship with detainees.[51] However, as noted earlier, the Instruction is not determinative of the law. The issue here turns upon the nature of their role in American detention centres: should they be treated akin to ordinary medical professionals, as akin to the BSCs or in a separate category on their own? The answer to this question will turn upon whether they also provided the detainees with basic medical care as did the other ordinary medical professionals (and so juggled the two roles) or whether they exclusively assisted the BSCs and did not provide basic medical care. If they provided basic medical care, then the fiduciary relationship would have been established (as discussed in Section 2.1. above). The information contained in the Instruction and the other evidence discussed in Chapter One does not permit a clear response to this question. However, it appears more likely that they acted in this dual capacity because if they assisted the BSCs exclusively, there would have been no reason to differentiate their role from that of a BSC.

2.3. The Behavioural Science Consultants

According to the Instruction, BSCs were not in a fiduciary relationship with the detainees (other than in emergencies) by virtue of the unique role that they played in American detention centres. While it is always possible that evidence will emerge to suggest otherwise in the future, it is very unlikely that a fiduciary relationship between the BSCs and the detainees was established by the BSC accepting that duty towards a detainee, apart from in cases of emergencies. In emergencies, as is recognised in the Instruction, BSCs will need to provide medical treatment, albeit if no other medical professionals were available.[52] In those circumstances, the BSCs would assume responsibility for detainees by way

[51] Instruction (n 9) E2.1.
[52] Instruction (n 9) 4.7.1.

of providing emergency care (stage one). As in the case of ordinary medical professionals, this is the most straightforward method of attaching a fiduciary relationship. In any other case, the Instruction explicitly advised that BSCs were not to misrepresent themselves as doctors providing medical care to detainees.[53] Nonetheless, if evidence were to emerge of BSCs undertaking affirmative actions, providing care to detainees, a fiduciary relationship would be deemed to be accepted, as in the case of the ordinary medical professionals above.[54]

Other kinds of conduct pose greater challenges. It is highly unlikely that applying the current legal standards discussed in Chapter Three, a BSC will be judged to have assumed fiduciary duties towards the detainees whose EITs they monitored (stage two) unless they undertook any further affirmative actions. Reports discussed in Chapter One suggest that some medical professionals monitoring the EITs (presumably the BSCs) would intervene to adjust detainees' oxygen level, even if this were not an emergency *per se*, and amend the EITs where necessary. Such interventions could be seen as an affirmative action to attach the fiduciary relationship. However, even where a fiduciary relationship is not assumed, it could be imposed by US courts in all the circumstances. As above, the question would be whether it is justifiable to impose a fiduciary relationship in all the circumstances. Here, BSCs were the only medical professionals that, according to the US Department of Defence, were present during EITs to monitor their immediate impact upon detainees.[55] This suggests a basis for arguing that the fiduciary relationship could be imposed to address the power imbalance between the parties and to protect the vulnerable detainee. Indeed, if BSCs were the only medical professionals present during the EITs, they would be the only doctors able to identify and act on situations in which the detainees required medical assistance (whether themselves or by calling other medical professionals to provide medical care).

[53] ibid E.2.1.8.
[54] *Mead* v *Adler* (2009) 321 Or App 451, 458.
[55] ibid E2.1.

Under stage three, developing new or altering existing EITs, a fiduciary relationship might be established if, for example, it is possible to prove that medical professionals assumed a duty of care towards detainees that may be affected by the EITs they advise on by way of taking affirmative steps to ensure their safety.[56] This would be the case if BSCs developed or altered EITs to protect detainees, for example, believing that their new or altered EITs would cause less pain and suffering in comparison with older methods. Understandably, this requires an examination of motivation rather than intent, hence of no significance for the issue of liability, and also poses a significant evidential burden. As with ordinary medical professionals, the fiduciary relationship can also be imposed here.

Again, while BSCs would not ordinarily hold a fiduciary relationship towards detainees, a fiduciary relationship may be imposed where they misuse the detainees' medical data for EITs (stage four) by way of sharing it with interrogators. By disclosing such private medical data, BSCs have created a peril to the lives and health of detainees and this may be enough for the court to impose a fiduciary relationship.[57]

It is unclear whether BSCs were under a duty to record medical data and if so, the scope of this duty. As such, the degree to which they may have engaged in falsifying evidence of the use of EITs is not known (stage five). The Instruction, the very document clarifying the scope of the duties of BSCs, is silent on the issue. BSCs were intended to have limited or no contact with the detainees,[58] the cases where BSCs could have been recording medical data are likely to be similarly limited, for example, when BSCs monitored the use of EITs (stage two) or when they provided emergency treatment (stages one and six of the taxonomy). Nonetheless, they would likely have been required to produce some form of documentation of their encounters. As discussed above, despite the Instruction suggesting otherwise, the fiduciary relationship can be established or imposed in those cases where BSCs record

[56] *Mead* v *Adler* (2009) 321 Or App 458. See Chapter Three.
[57] *McCormick* v *England* (1997) 494 S.E.2d 431, 436-37.
[58] See: Chapter Three, Section 2.

medical data, and so BSCs would have been under a duty to record medical data truthfully and accurately.[59]

In cases of BSCs who intervened to provide treatment in emergencies to facilitate further EITs (stage six), it may be argued that they assumed the fiduciary duty of care towards the detainee by the very act of undertaking the life-saving treatment.[60] In *Mead* v *Adler*, it was said that: 'in the absence of an express agreement by the physician to treat a patient, a physician's assent to a physician-patient relationship can be inferred when the physician takes an affirmative action concerning the care of the patient.'[61] Furthermore, BSCs who treated detainees and so facilitated EITs (stage six), created a peril to the detainees' lives and health which would then open the door to attach a fiduciary relationship. In line with the decision in *Tarasoff* v *Regents of the University of California*,[62] a fiduciary duty might be imposed on BSCs having considered all of the circumstances,[63] especially 'the type and foreseeability of risk and the magnitude and consequences.'[64] According to the US Administration, only BSCs were to advise on what EITs to use or how to tailor them following the detainees' vulnerabilities (stage seven). As discussed above in the context of ordinary medical professionals, this is a significant activity, liable to create a peril to lives and health of the detainees which may have not existed (or not existed to the same extent) but for their involvement.[65] Stage seven concerns a more direct way of creating peril for a specific detainee in comparison with less definite cases, for example, altering the existing EITs (stage three) and misusing detainees' medical data for EITs (stage four). This may be the deciding distinction for courts to impose the fiduciary relationship in this case.

Force-feeding (stage eight) is not a recognised EIT. If it is seen as basic care for the detainee, it would therefore generally be considered as amounting to affirmative action and the care of the patient.[66]

[59] See: Chapter Five, Section 4.1.
[60] For the analysis of assumption of the fiduciary relationship see Chapter Three, Section 3.
[61] *Mead* v *Adler* (2009) 321 Or App 451, 458.
[62] *Tarasoff* v *Regents of the University of California* (1976) 17 Cal.3d 425,551 P2d 334.
[63] Robert I. Simon and Daniel W. Shuman, 'The Doctor-Patient Relationship' (2007) 5 *Focus* 423.
[64] *Safer* v *Estate of Pack* (1996)291 NJ Super 619, 677 A2d 1188.
[65] *Trombley* v *Kolts* (1938) 29 Cal. App. 2d 699 [85 P.2d 541]. See: Section 3.
[66] *Mead* v *Adler* (2009) 321 Or App 451, 458.

While, according to the US Administration, BSCs were not to be engaged in the provision of care generally, they may have been involved in force-feeding as an emergency procedure, there they acted to preserve the detainee's life. In cases of emergencies, a fiduciary relationship would be established, as shown above. Furthermore, in the case of force-feeding, and especially where detainees are subjected to treatment such as Abu Wa'el Dhiad discussed in Chapter One, it may be further argued that fiduciary duties will follow as the force-feeding exposes the detainees to peril.

BSCs who are not in a fiduciary relationship with the detainees are not under a duty to provide medical care to the detainees. Considering their alleged limited involvement in the provision of medical care, the only possible scenario where withdrawing or withholding basic medical care would be actionable is in the case of emergencies. In emergencies and especially where there are no other medical professionals to provide emergency care, courts would likely impose a fiduciary relationship, in line with the jurisprudence discussed in Chapter Three. Where BSCs provide medical care just to withdraw it shortly after, the fiduciary relationship would have been attached by the affirmative act of providing care. Where BSCs are under a duty to provide medical care and intentionally fail to do so or begin to provide medical care and withdraw it to punish the detainee, such conduct would constitute a breach.

Generally, when participating directly in EITs (stage ten), BSCs could be said to have assumed a duty of care for the detainees, as, relying on the US Administration's own claims, they were engaged in the EITs to ensure that they were 'safe, legal, and effective.'[67] The argument is that BSCs accept the duty of care by way of implementing the EITs themselves and in a way that is safe, legal and effective. However, considering that it is questionable whether EITs could ever be safe, legal and effective, which BSCs must or should have known, it is similarly questionable whether the BSCs could have assumed a duty of care by way of implementing the EITs themselves. Alternatively, a court might impose a fiduciary relationship in cases where medical professionals caused peril to the lives or health

[67] Jay S. Bybee, 'Memorandum to Alberto R. Gonzales' (2002).

of detainees, by way of inflicting EITs.[68] In participating in EITs, BSCs would have exposed detainees to a foreseeable risk to their lives and health.[69]

In summary, the above analysis shows that despite the US Administration distinguishing between the ordinary medical professionals and the BSCs, based on the different roles they undertook, the fiduciary relationship could be established in the majority of cases. This is reflective of current jurisprudence where the fiduciary relationship is attached and medical professionals accept or assume a fiduciary duty towards detainees (as patients), or where the courts impose the fiduciary relationship in all the circumstances (and specifically in cases of emergency and where the medical professionals create peril to the lives and health of the detainees). The above discussion demonstrates that ordinary medical professionals are highly likely to be in a fiduciary relationship with the detainees when undertaking the different activities undertaken in American detention centres. This is to be expected, as ordinary medical professionals were responsible for the health and wellbeing of the detainees. The fiduciary relationship between the other types of medical professionals and detainees is more challenging to establish although, as demonstrated above, not impossible. Given the activities undertaken, the power imbalance between the parties, and the possible health consequences to the detainees, the courts are likely to require a higher threshold of conduct (typical of a fiduciary relationship) and so impose such a relationship. This is specifically where medical professionals, with their conduct, create a peril to the lives and health of the detainees.

Understandably, at this stage, this is a theoretical question that has not been tested by courts. While the issue of accepting or assuming a fiduciary relationship would follow the existing jurisprudence, it may require some judicial activism, for example, to engage with the question of involvement in EITs as constituting peril to the detainees. The jurisprudence discussed in Chapter Three, relating to the imposition of a fiduciary relationship, shows that courts have not shied away from taking to a pro-

[68] *Trombley* v *Kolts* (1938) 29 Cal. App. 2d 699 [85 P.2d 541].
[69] See: Section 2.1. (above). Also: *Trombley* v *Kolts (1938)* 29 Cal. App. 2d 699 [85 P.2d 541]; *Hardy* v *Brooks* (1961) 103 Ga. App. 124, 126 (118 SE2d 492).

active approach to the issue and demonstrating a willingness to recognise the duties of medical professionals. However, understandably, the case of American detention centres provides for a hugely different context, and there are significant evidentiary hurdles that would need to be tackled.

3. Could Medical Professionals Have Legitimate Expectations not to be in the Fiduciary Relationship?

The above analysis shows the flaws in the guidance offered to medical professionals by the US Administration, and especially within the Instruction, which incorrectly omits certain methods of attaching a fiduciary relationship. However, one further important question must be addressed: whether the medical professionals could reasonably rely on the Instruction (or even the legal opinions discussed in Chapter Two) as a defence for failing to adhere to the law. Does the document create a legitimate expectation of protection from legal accountability, including for breaches of the fiduciary relationship?

The doctrine of legitimate expectation, although not univocally defined, establishes the basic requirement for the law to provide clarity and certainty. In *Moragne* v *States Marine Lines, Inc.*, the court found that the doctrine of reasonable expectation concerns 'the desirability that the law furnishes a clear guide for the conduct of individuals, to enable them to plan their affairs with assurance against untoward surprise.'[70] However, this does not preclude flexibility. Indeed, as Margaret J. Radin, professor of law, notes, 'where the line of evolution of legal interpretation is foreseeable, it would not be unfair to hold people to what they can see is the emerging interpretation.'[71] This section considers these two aspects of legal certainty and flexibility and how they may affect the potential liability of medical professionals who worked in detention centres. Throughout this analysis, it is important to remember that the doctrine of reasonable expectations applies to the law while the documents that medical professionals would wish to rely on are legal

[70] *Moragne* v *States Marine Lines, Inc.* (1970) 398 US 375, 403.
[71] Margaret J. Radin, 'Reconsidering the Rule of Law' (1989) 69 Boston University Law Review 781, 815.

opinions and guidance documents only. The question would be whether it is reasonable for them to assume that these documents state the law?

In the case study of the thesis, there is a specific provision affirming the good faith defence in Section 1404(a) of the Detainee Treatment Act of 2005 stating that:

> In any civil action or criminal prosecution against an officer, employee, member of the Armed Forces, or other agent of the United States Government who is a United States person, arising out of … engaging in specific operational practices, that involve detention and interrogation of aliens who the President or his designees have determined are believed to be engaged in or associated with international terrorist activity that poses a serious, continuing threat to the United States, its interests, or its allies, and that were officially authorised and determined to be lawful at the time that they were conducted, *it shall be a defence that such officer, employee, member of the Armed Forces, or other agent did not know that the practices were unlawful and a person of ordinary sense and understanding would not know the practices were unlawful.*[72]

The provision further states that 'Good faith reliance on the advice of counsel should be an important factor, among others, to consider in assessing whether a person of ordinary sense and understanding would have known the practices to be unlawful.'[73]

It may be argued that some medical professionals have a legitimate expectation[74] that they would not be in a fiduciary relationship with detainees,[75] given the advice offered in the Instruction. Similarly, as per the legal opinion, medical professionals could have a legitimate expectation that the EITs do

[72] Section 1404(a) of the Detainee Treatment Act of 2005, Public Law 163-109, 119 Stat. 3136, 6 January 2006. [emphasis added].
[73] ibid.
[74] Daphne Barak-Erez, 'The Doctrine of Legitimate Expectations and the Distinction between the Reliance and Expectation Interests' (2005) 11 *European Public Law* 584. However, the application of the doctrine in the US is limited. See: Lon L. Fuller and William R. Perdue 'The Reliance Interest in Contract Damages' (1936) 46 *Yale Law Journal* 373.
[75] Instruction (n 9) 4.3.

not constitute torture or other criminal acts. However, as the above section shows, the Instruction in itself poses numerous challenges as it does not accurately reflect the law, meaning that its validity is questionable. As such, ought the medical professionals to have ignored the Instruction where it contradicted the law? The answer to this question can only be yes, as ignorance or mistake of law is no excuse.[76] The medical professionals relying on the Instruction may thus find themselves in violation of the law.

Medical professionals are expected to know the law that applies to them and to adhere to it. This is reflected in the jurisprudence of the Nuremberg Trials, where the tribunal considered whether the accused could be prosecuted for acts that were following the law. There, the prosecutors made a distinction between the accused's knowledge that their actions were wrong and their knowledge and foreseeability of legal sanctions for their actions. This meant that while the accused believed that they would not be prosecuted for their actions as they were authorised by Nazi law, they were aware or ought to have been aware that their actions were wrong.[77] However, the case study of this thesis might be distinguished in that the law (whether concerning torture or the fiduciary relationship) remained the same. It was only an official explanation of it (the Instruction, legal opinions and governmental memoranda) which differed, seeking to preclude the existence of the fiduciary relationship and to justify the use of EITs. This difference makes the legitimate expectation argument much weaker in the case of medical professionals in American detention centres than it was at Nuremberg. As such, it is less likely to succeed in this context. Nonetheless, in a functioning democracy, people should be entitled to rely on the opinions of government legal advisors. How else are non-lawyers going to get

[76] Edwin R. Keedy, 'Ignorance and Mistake in the Criminal Law' (1908) 22 *Harvard Law Review* 75, 77. However, as the court in *Cheek* v *United States* (1991) 498 U.S. 192 held, where one has good faith belief that one does not violate the law because of the complexity of law (here tax law), the mental elements of the crime may not be established. Similarly, court have found that where a piece of legislations is too vague, 'men of common intelligence cannot be required to guess at the meaning of [a criminal] enactment.' *Winters* v *New York* (1948) 333 U.S. 507, 515 (1948).

[77] Henry Donnedieu de Vabres, 'The Nuremberg Trial and the Modern Principles of International Criminal Law' in Guenael Mettraux (ed.), *Perspectives on the Nuremberg Trial* (Oxford University Press: New York, 2010) 271; David Luban, 'The Legacies of Nuremberg' in Guenael Mettraux (ed.), *Perspectives on the Nuremberg Trial* (Oxford University Press: New York, 2010) 655; Telford Taylor, 'The Nuremberg Trials' in Guenael Mettraux (ed.) *Perspectives on the Nuremberg Trial Perspectives on the Nuremberg Trial* (Oxford University Press: New York, 2010) 384; Stanley L. Paulson, 'Classical Legal Positivism at Nuremberg' (1975) 4 *Philosophy and Public Affairs* 132; David Luban, Alan Strudler and David Wasserman, 'Moral Responsibility in the Age of Bureaucracy' (1992) 90 *Michigan Law Review* 2348.

their understanding of the law? However, where the legal opinions contradict the law which medical professionals should know as it applies to them, the reliance on the legal opinions would not be reasonable.

4. Conclusion

The chapter has shown that the US Administration's univocal denial of the fiduciary relationship between BSCs (or the ordinary medical professionals assisting BSCs) and detainees is erroneous and contrary to US law. While the potential fiduciary relationship would have to be considered on a case-by-case basis, the above analysis provides some guidance on the important considerations that could influence this determination. As is clear from the analysis in this chapter, the issue of a fiduciary relationship between the medical professionals and the detainees is not as unequivocal as presented by the US Administration. Rather, the doctor-patient fiduciary relationship between ordinary medical professionals and detainees will be established in all or most cases, while for BSCs, there will be cases where this relationship can be established or imposed even though the US Administration argues otherwise. This is because the fiduciary relationship is not established by a label, but by virtue of the acts undertaken by the fiduciary, for example, by accepting or assuming the responsibility the detainees or where it is just to impose it in all the circumstances.[78] As Finn argues, one 'is not subject to fiduciary obligations because he is a fiduciary; it is because he is subject to them that he is a fiduciary.'[79] Considering the ten stages of the taxonomy, as the involvement of medical professionals becomes more severe in terms of *actus reus* (and as such more harmful and further removed from the best interests of detainees), it becomes more difficult to establish a fiduciary relationship (by way of assuming or accepting the duty). However, as the engagement becomes more severe, and it becomes more likely to create peril, a fiduciary relationship becomes more likely.

[78] *Bristol & West Building Society* v *Mothew* (1998) Ch. 1 CA at 18. See also*:* Finn (n 12) 2.
[79] Finn (n 12) 2.

However, certain cases will likely pose challenges to the existing jurisprudence, for example, under stage two where medical professionals monitor EITs but do not provide any medical care or take other affirmative actions. This is an important consideration, as will be seen in Chapter Seven, the possibility of establishing a fiduciary relationship will be crucial in any attempt to hold medical professionals in American detention centres accountable for their involvement in EITs. As such, we now encounter a second problem. Even where one can accept that there will be cases where a fiduciary relationship between medical professionals and detainees is established or imposed, medical professionals (either the ordinary medical professionals or the BSCs) may seek to rely on the second argument advanced by the US Administration: that they have conflicting loyalties that would make it impossible to fulfil duties towards their patients. This argument is put to the test in the following chapters.

CHAPTER FIVE: Challenging the Dual Loyalties Argument in Cases of Criminal Conduct

1. Introduction

As the previous chapter demonstrated, medical professionals in American detention centres were frequently in a fiduciary relationship with specific detainees, although the basis for establishing this relationship differs depending on their actual involvement in EITs. The existence of such a fiduciary relationship prescribes fiduciary duties that medical professionals are legally obliged to follow. However, medical professionals are also subject to duties towards others that may affect their ability to act with undivided loyalty towards their patients, compromising the fiduciary relationship albeit not entirely eradicating the fiduciary duties.[1]

This chapter and the next argue that medical professionals in American detention centres should act in compliance with their fiduciary duties towards detainees (most of the time unless in exceptional circumstances).[2] This involves challenging the second element of the US Administration's argument for why medical professionals in American detention centres are not legally liable for what would otherwise be unlawful conduct: the doctrine of dual loyalties, which is used to claim that medical duties towards patients are set aside – as a blanket exclusion – in preference to their duties towards the state.[3] The argument proceeds in two stages, reflecting on the important distinction between those cases where the norms of appropriate medical conduct are breached in ways that are sufficiently serious to potentially attract criminal liability,[4] and conduct that may fall below this threshold but

[1] James Edelman, 'When Do Fiduciary Duties Arise?' (2010) *126 Law Quarterly Review* 302.
[2] This is discussed later in the chapter.
[3] The Instruction identifies the practices that the BSCs were to follow. The guidance is given to the ordinary medical professionals in 4.7.1. that explicitly places the state above the detainee (patient). US Department of Defence, 'Instruction 2310.08E, Medical Program support for detainee operations' (6 June 2006).
[4] Specifically, where medical professionals develop new or tailor existing EITs (stage three), falsify the evidence of the use of EITs (stage five), treat injuries to facilitate further use of EITs (stage six), advise on and tailor EITs for a specific detainee *(stage* seven), and directly participate in EITs (stage ten of the taxonomy).

would nonetheless attract civil or disciplinary liability.[5] The former will be considered in this chapter, the latter in Chapter Six.

This chapter, having briefly reminded the reader of the meaning of the dual loyalties doctrine and the role that it plays in the US Administration's claim (Section 2), contests the presumption that medical and military duties are always and inevitably in conflict. First, it argues that, while, as a matter of empirical fact, medical professionals may sometimes perceive there to be such a conflict, this is caused by a mistaken understanding of the relevant law, possibly influenced by a strong sense of institutional loyalty (Section 3). Second, it argues that in many cases, where their involvement amounts to criminal conduct, medical and military duties are coterminous, as both doctors and soldiers share in a legal duty not to engage in criminal conduct (Section 4). This is relevant to those stages of the taxonomy that require more active involvement, namely, where medical professionals develop new or tailor existing EITs (stage three of the taxonomy), falsify evidence of the use of EITs (stage five), treat injuries to facilitate further use of EITs (stage six), advise on and tailor EITs to a specific detainee (stage seven), and directly participate in EITs (stage ten). This thesis argues that the dual loyalties doctrine does not and cannot offer a legal justification or excuse for these forms of conduct. Cases of lesser, non-criminal conduct where the dual loyalties argument may apply, are discussed in the following chapter.

2. The Dual Loyalty Doctrine and Its Role in the US Administration's Claim

Once the fiduciary relationship is established, it is clear that medical professionals have certain duties towards their patients.[6] However, aside from fiduciary duties owed to their patients, medical professionals have concurring obligations to other parties, for example, their employer, the insurer or

[5] Where medical professionals provide basic medical care (stage one), monitor the use of EITs (stage two), misuse detainees' medical data for the purposes of EITs (stage four), but also force-feed (stage eight) and withdraw or withhold basic medical care (stage nine) in certain cases.
[6] See Paul Finn, 'Fiduciary Reflections' (2014) 88 *Australian Law Journal* 127; Edelman (n 1) 302.

the state, resulting in dual loyalties.[7] The term dual loyalties refers to the competing obligations placed on medical professionals: towards their patients and towards third parties that may 'conflict with the undivided devotion to the patient.'[8] Dual loyalties conflicts are not uncommon and are not unique to institutions like detention centres. The consensus within the academic literature on the topic, predominately from the medical ethic and also military fields, is that, in the case of military doctors, medical and military obligations are, at least sometimes, likely to come into conflict.[9] Generally, in the military and other similar institutions, including detention centres, a conflict between different duties may occur between considerations of what is medically in the best interests of the patient and what is in the best interest of national security, the safety of other military staff, and situational and tactical constraints, and the corresponding duties.[10]

Marc Rodwin, professor of law, suggests that: 'physicians have divided loyalties when they perform roles other than patient care or serve two or more patients with diverging interests.'[11] These two scenarios are very broad and may suggest that there is virtually no scenario where medical professionals would not simultaneously hold duties to parties other than their patients.[12] Importantly, Rodwin does not suggest that the existence of such dual loyalties would ultimately result in

[7] Neil E. Weisfeld, Victoria D. Weisfeld, and Catharyn T. Liverman, *Military Medical Ethics: Issues Regarding Dual Loyalties. Workshop Summary* (National Academies Press: Washington DC, 2009); Gregg M. Bloche, 'Clinical Loyalties and the Social Purposes of Medicine' (1999) 281 *Journal of the American Medical Association* 268-74.
[8] Leonard S. Rubenstein, 'Dual Loyalties and Human Rights' (2003) 26 *Journal of Ambulatory Care Management* 270.
[9] Victor W. Sidel and Barry S. Levy, 'Physician-Soldier: A Moral Dilemma' in Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 296; Edmund G. Howe, 'Point/Counterpoint--A response to Drs Sidel and Levy (Physician-Soldier: A Moral Dilemma)' in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 320; Leslie London, Leonard S. Rubenstein, Laurel Baldwin-Ragaven, and Adriaan Van Es, 'Dual Loyalty among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict' (2006) 15 *Cambridge Quarterly of Healthcare Ethics* 381.
[10] Edmund G. Howe, 'Mixed Agency in Military Medicine: Ethical Roles in Conflict' in Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 334; Norman Daniels and James Sabin, 'Limits to Health Care: Fair Procedures, Democratic Deliberation and the Legitimacy Problem for Insurers' (1997) 26 *Philos Public Affairs* 303.
[11] Marc A. Rodwin, 'Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System' (1995) 21 *American Journal of Law and Medicine* 251. See also: Stephen Toulon, 'Divided Loyalties and Ambiguous Relationships' (1986) 23 *Social Science and Medicine* 783.
[12] Mark G. Field, 'Structured Strain in the Role of the Soviet Physicians' (1953) 58 *American Journal of Sociology* 493; Toulon (n 11) 783.

undermining duties towards patients. As such, it is important to consider what it means to the medical professionals' duties towards their patients and how far the fiduciary relationship is affected.

Some common examples of dual loyalties conflict include medical professionals facing challenges to their fiduciary relationship because of difficult choices concerning the allocation of available resources[13] or evaluating patients for adjudicative purposes.[14] Other examples include cases where medical professionals have to choose between their duty of doctor-patient confidentiality[15] and their duty to notify state agencies about contagious diseases[16] or to protect patients and others from a patient's destructive tendencies,[17] including to protect an identifiable third party at risk of serious immediate harm.[18] A dual loyalties conflict may also occur between what the medical professional believes is in the best interest of the patient and what the hospital or another supervisory body believes to be the most reasonable course of action in the circumstances.[19] There may be financial or legal constraints,[20] or other considerations preventing the medical professionals from acting with undivided loyalty to their patients. In addition to these examples, Leonard Rubenstein, a legal scholar of human rights and medical ethics in conflict, notes that medical professionals globally are increasingly asked to subordinate the best interest of their patients to achieve other objectives.[21] However, the increasing number of pressures will not always justify medical professionals abandoning their duties towards

[13] Bruce E. Zawacki, 'ICU Physician's Ethical Role in Distributing Scarce Resources' (1985) 13 *Critical Care Medicine* 57.
[14] Solomon R. Benatar and Ross E.G. Upshur, 'Dual Loyalties of Physicians in the Military and Civilian Life' (2008) 12 *Public Health and the Military* 2161.
[15] James F. Childress, Ruth R. Faden, Ruth D. Gaare, *et al*., 'Public health ethics: mapping the terrain' (2002) 30 *Journal of Law, Medicine and Ethics* 170.
[16] Nancy E. Kass, 'Public Health Ethics: From Foundations and Frameworks to Justice and Global Public Health' (2004) 32 *Journal of Law, Medicine and Ethics* 232; Ronald Bayer, 'Public Health Policy and the AIDS Epidemic. An End to HIV Exceptionalism?' (1991) 324 *New England Journal of Medicine* 1500.
[17] Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Springer: Dordrecht, 2008)16.
[18] *Tarasoff* v *Regents of the University of California* (1986) 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14; Tomas S. Szasz, *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (Collier Books: New York, 1971) 45-46; Thomas H. Murray, 'Divided Loyalties in Sports Medicine' (1984) 12 *Physician and Sports Medicine* 134; Edmund G. Howe, 'Ethical Issues Regarding Mixed Agency of Military Physicians' (1986) 23 *Social Science and Medicine* 803; Diana Chapman Walsh, 'Divided Loyalties in Medicine: The Ambivalence of Occupational Medical Practice' (1986) 23 *Social Science and Medicine* 789.
[19] Kass (n 16).
[20] Solomon R. Benatar, 'Facing Ethical Challenges in Rolling-out Antiretroviral Treatment in Resource-poor Settings' (2006) 15 *Cambridge Quarterly Health Ethics* 322.
[21] Rubenstein (n 8) 270.

patients. Nonetheless, the prevalence of dual loyalties and the risk of failure to perform duties towards patients erodes important aspects of the concept of the fiduciary relationship.

In the case study of this thesis, apart from the kinds of possible conflict set out above, medical professionals may hold certain duties towards the state that flow from their engagement by the military. Indeed, the US Administration has relied on the conflict between the duty owed to the state and the demands of national security (given additional weight because of the War on Terror) to justify medical involvement in EITs.[22] In relying on these arguments, the US Administration claims that those duties trump fiduciary duties that medical professionals may have had towards detainees.[23] In response, this thesis argues that the dual loyalty conflict cannot be presumed, and needs to be analysed on a case-by-case basis. There are certain cases where despite the existence of duties towards multiple actors, these duties do align, meaning that there would be no need for doctors to choose which duties to discharge.

3. The Presumption of a Dual Loyalties Conflict

There will be a few situations where medical professionals have dual loyalties. This thesis argues that, where the circumstances do arise, this does not mean that a medical professional's duties would always and inevitably conflict forcing them to choose which duties to discharge and which to abandon. This thesis acknowledges the complexity of the reality faced by medical professionals embedded within the military, a position shared by Mehring.[24] However, contrary to Mehring who argues that 'when faced with a conflict between military and medical loyalty, military physicians either forsake their neutrality and side with the former, or physicians honour their medical oath and

[22] Jay S. Bybee, 'Memorandum to Alberto R. Gonzales, Standards for Conduct for Interrogation under 18 U.S.C. 2340 - 2340A' (1 August 2002) 6.
[23] ibid.
[24] Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* (Brill Nijhoff: Leiden, 2014). Mehring, who scrutinised the role of medical professionals in armed conflicts, considers duties and obligations not only of military medical professionals, but also of civilian medical professionals working in areas of armed conflicts, medics within humanitarian organisations, and challenges that they may encounter.

decide against their military and in favour of their medical loyalties',[25] this is not necessarily always the result of dual loyalties conflict.

Here, it is crucial to consider the unique situation in which medical professionals in American detention centres find themselves. As William Madden and Brian Carter claim, both medical professionals, military medical professionals are not just medical professionals working in a crisis situation, they are also military professionals embedded within an institution.[26] While the state of crisis might place various strains on the medical professionals' ability to act in the best interest of their patients, it may be their placement within an institution that has the most significant effect upon them.[27] However, this does not necessarily reflect the legal duties that they have. As this thesis argues, medical and military legal duties relating to torture, and other kinds of criminal conduct,[28] are

[25] ibid 23.

[26] William Madden and Brian S. Carter, 'Physician-Soldier: A Moral Position' in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 269.

[27] Mehring (n 24) 393; Robert J. Lifton, 'Doctors and Torture' (2004) 351 *New England Journal of Medicine* 415-416. Lifton suggests the existence of an atrocity-producing situation leading to ordinary people becoming engaged in atrocities. He notes that: 'even without directly participating in the abuse, doctors may have become socialised to an environment of torture and by virtue of their medical authority helped sustain it. In studying various forms of medical abuse, I have found that the participation of doctors can confer an aura of legitimacy and can even create an illusion of therapy and healing.' ibid. 412.

[28] Including, for example, the crimes of simple and aggravated assault/battery, recklessly endangering another person or criminal harassment.

§211.1 of the Model Penal Code consolidates the common law crimes of mayhem, battery, and assault as follows:

'(1) Simple Assault. A person is guilty of assault if he:

(a) attempts to cause or purposely, knowingly, or recklessly causes bodily injury to another; or

(b) negligently causes bodily injury to another with a deadly weapon; or

(c) attempts by physical menace to put another in fear of imminent serious bodily injury.

Simple assault is a misdemeanour unless committed in a fight or scuffle entered into by mutual consent, in which case it is a petty misdemeanour.

(2) Aggravated Assault. A person is guilty of aggravated assault if he:

(a) attempts to cause serious bodily injury to another, or causes such injury purposely, knowingly, or recklessly under circumstances manifesting extreme indifference to the value of human life; or

(b) attempts to cause or purposely or knowingly causes bodily injury to another with a deadly weapon.

Aggravated assault under paragraph (a) is a felony of the second degree; aggravated assault under paragraph (b) is a felony of the third degree.'

§211.2 of the Model Penal Code defines recklessly endangering another person as:

'A person commits a misdemeanour if he recklessly engages in conduct which places or may place another person in danger of death or serious bodily injury. Recklessness and danger shall be presumed where a person knowingly points a firearm at or in the direction of another, whether or not the actor believed the firearm to be loaded.

§250.4 of the Model Penal Code defines harassment as: "A person commits a petty misdemeanour if, with purpose to harass another, he: …

(2) insults, taunts or challenges another in a manner likely to provoke violent or disorderly response; or

(3) makes repeated communications anonymously or at extremely inconvenient hours, or in offensively coarse language; or

(4) subjects another to an offensive touching; or

(5) engages in any other course of alarming conduct serving no legitimate purpose of the actor.'

remarkably similar in that both professions are prohibited from engaging in their use, even if the duties originate from different places with different policy reasons.

The conflict between the medical and military duties of military medical professionals is often assumed to exist because of their fundamentally different roles.[29] Despite these differences, what unites them is that both doctors and soldiers are bound by legal and professional norms that would prevent them from engaging in criminal acts. For example, soldiers are bound to adhere to domestic and international laws including laws prohibiting criminal conduct.[30] This standard also applies to soldiers on the battlefield, who can kill and be killed, yet they must follow the law of war and armed conflicts.[31] They are not allowed to engage in criminal activities as such involvement would contradict international humanitarian law. Soldiers are subject to *jus in bello* rules requiring them to use proportionate force against combatants.[32] Soldiers are not to torture or inflict unnecessary pain and suffering.[33] As such, involvement in torture, constituting a grave breach of the Geneva Conventions,[34] cannot be used as a weapon of war by soldiers.[35] Furthermore, in addition to legal duties, Mark J. Osiel, professor of law, convincingly argues that soldiers owe moral duties to enemy troops and co-combatants by virtue of their humanity.[36] He notes that 'even empathy is an essential martial virtue. Effective soldiers never deny the humanity of their adversary. Recognising key aspects of this humanity is necessary to anticipate the enemy's likely actions and reactions.'[37] Similarly,

[29] Daniel Messelken, 'Conflict of Roles and Duties - Why Military Doctors are Doctors' (2015) 1 *Ethics and Armed Forces* 44.
[30] See for example, the Uniform Code of Military Justice, the Geneva Conventions.
[31] Common Article 1 of the 1949 Geneva Conventions, Article 1(1) of the 1977 Additional Protocol I.
[32] Article 51(5)(b) of the 1977 Additional Protocol I, Article 26(3)(b) of the Additional Protocol II, Article 3(3)(c) of the 1980 Protocol II to the Convention on Certain Conventional Weapons, Article 15 of the 1863 Lieber Code.
[33] Article 35(2) of the 1977 Additional Protocol I: 'It is prohibited to employ weapons, projectiles and material and methods of warfare of a nature to cause superfluous injury or unnecessary suffering.' Article 20(2) of the Additional Protocol II: 'It is forbidden to employ weapons, projectiles, and material and methods of combat of a nature to cause superfluous injury or unnecessary suffering.' This is also confirmed in the Rome Statute and the Convention on Certain Conventional Weapons.
[34] Geneva Convention I, Article 12; Geneva Convention II, Article 12; Geneva Convention III, Articles 13, 17 and 87; Geneva Convention IV, Articles 27 and 32; Geneva Convention I-IV common article 3, Articles 50, 51, 130 and 147 respectively; Additional Protocol I of 1977 (Article 75(2)(a)(ii)); and Additional Protocol II of 1977 (Article 4(2)(a)).
[35] Oren Gross, 'The Grave Breaches System and the Armed Conflict in the Former Yugoslavia' (1995) 16 Michigan Journal of International Law 801; Jean S. Pictet (ed.), *IV The Geneva Convention of 12 August 1949: Commentary* (International Committee of the Red Cross: Geneva, 1952) 598.
[36] Mark J. Osiel, 'Obeying Orders: Atrocity, Military Discipline, and the Law of War' (1998) *California Law Review* 1027.
[37] ibid.

medical professionals are bound to adhere to the law and medical professional norms including the duty to respect a patient's autonomy, nonmaleficence, beneficence, and justice.[38]

However, as previously identified, these duties, even if similar, have different origins. The role of soldiers derives from and is focused on national necessity,[39] national security, and the collective good,[40] while the role of the medical professionals derives from and is focused on medical necessity and individual good.[41] Daniel Messelken, a scholar on military medical ethics, suggests that 'soldiers defend their country and fellow citizens; doctors cure their patients.'[42] He further adds that 'whereas medical ethics follows an individual logic, focusing on the patient's well-being, military ethics adopt a collective point of view, aiming for national security and the survival of a group, and hence follows a collective logic.'[43] This means that a soldier will aim to save the lives of citizens and (his fellow or friendly) soldiers, while a medical professional will aim to save lives of all patients, independent of whether they are citizens or foreigners, fellow or enemy soldiers.[44] Messelken convincing argues that the duties of medical professionals engaged in the military are 'determined not only by international law but primarily by the rules of medical ethics.'[45] Soldiers' duties are to defend liberty, territory and security,[46] while doctors' duties are to maximise the quality-adjusted life years, well-being, and normal functioning.[47] Because of those fundamental differences, medical and military duties may be seen as conflicting and pose the challenge of dual loyalties.

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[38] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (Oxford University Press: New York, 2001) 12.
[39] This military necessity 'consists in the necessity of those measures which are indispensable for securing the ends of the war.' Article 14 of the Lieber Code of 1863. However, such measures still need to be lawful.
[40] Messelken (n 29) 44; Gregg M. Bloche and Jonathan H. Marks, 'When Doctors Go to War' (2005) 352 *The New England Journal of Medicine* 3.
[41] Michael L. Gross, 'Bioethics and Armed Conflicts. Mapping the Moral Dilemmas of Medicine and War' (2004) 6 *Hasting Centre Report* 29, 34; Messelken (n 29) 44.
[42] Messelken (n 29) 44.
[43] ibid.
[44] Geneva Convention I, Article 12, second para.; Article 15, first para.; Geneva Convention II, Article 12, second para.; Article 18, first para.; Article 21, first para.; Geneva Convention IV, Article 16, first para.; Additional Protocol I, Article 10; Additional Protocol II, Articles 7, 8 and 18(1).
[45] Messelken (n 29).
[46] ibid.
[47] *See* Beauchamp and Childress (n 38) 6-10.

Based on the assumption that medical and military duties inevitably clash, there have been debates about whether medical professionals should engage with the military at all. The debate between Barry S. Sidel and Victor W. Levy, Edmund G. Howe and Dominick R. Rascona is illustrative. Sidel and Levy, both physicians who have written extensively on the issue of medical ethics, claim that military and medical obligations are always and inevitably in conflict as a matter of principle and, hence, medical professionals should not work in the military.[48] They say that this creates an erroneous feeling of 'institutional loyalties' that ultimately impacts upon a doctor's decision-making and loyalty towards his or her patients.[49] They assert that this institutional loyalty to the military, which is deeply rooted in military medical training, teaches medical professionals to be a soldier first, and a medical professional second, without due attention to their legal obligations, either as medical professionals or as soldiers.[50] This is also why, according to them, medical professionals in the military would routinely choose to adhere to what they consider to be their military duties, whether genuine or embedded institutional loyalty,[51] by default, even though such a position is highly controversial and contrary to legal and professional standards.[52] However, Sidel and Levy's argument is flawed in that it conflates the psychological fact of institutional loyalty with the legal fact of military duties, erroneously presenting them as coterminous. This allows them to reach the incorrect conclusion that medical professionals should not engage in military roles, rather than exploring how to ensure that medical professionals are able to act in both capacities as a doctor and soldier. The question should be, how can we achieve this?

[48] Sidel and Levy (n 9) 296.
[49] In line with Sidel and Levy, Messelken alleges that: 'By being part of the military unit, these physician-soldiers are more likely to agree that such a reprehensible action as participating in torture might be justified under some circumstances. This tendency to over-identify with the unit, its personal, and its mission, is yet another reason why physicians should not be a formal part of these military organisations.' Messelken (n 29).
[50] ibid.
[51] Mehring claims that the institutional loyalties are a result of medical professional being embedded in the military: 'Because the armed forces are employer and educator, military physicians are highly dependent on them. As part of the armed forces, they work in military hospitals under military command following military manuals. They are trained with, live with, eat with, [and] spend time with a military unit. This forges an emotional and professional bond between the military physicians and troops.' Mehring (n 24) 23.
[52] See: Project of the International Dual Loyalty Working Group, 'Dual Loyalty in Health and Professional Practice: Proposed Guidelines and Institutional Mechanisms' (Physicians for Human Rights and the University of Cape Town Health Sciences Faculty; Cape Town, South Africa, 2002); Beauchamp and Childress (n 38) 3.

Howe, an ethicist, responds to Sidel and Levy by asserting that medical professionals are vital to the military and, once attached, must be 'committed to doing what is required to secure victory.'[53] He claims that 'as opposed to needing neutral physicians, we need military physicians who can and do identify as closely as possible with the military so that they, too, can carry out the vital part they play in meeting the needs of the mission.'[54] This may mean abandoning their loyalties to patients in order to fulfil their military duties. Howe convincingly reasons that Sidel and Levy confuse principle and empirical fact.[55] He also notes that while medical and military obligations are not in conflict as a matter of principle, they are very likely (almost inevitably) to conflict as a matter of empirical fact, given the lived reality of the military.[56] Indeed, this thesis argues that while military and medical duties may align, it may be institutional loyalty (as the lived reality) that results in medical professionals abandoning their medical duties when in the military.[57] As such, it is not the law that is the problem or the answer.

Howe asserts that medical professionals should be allowed to serve in the military as he trusts that where dual loyalty conflicts occur, medical professionals would be able to juggle the two roles of medical professional and soldier.[58] This position allows more flexibility than Sidel and Levy, however, Howe's claim does not resolve the underlying issue of institutional loyalties. If indeed institutional loyalty is the lived reality of the military, it seems unlikely that medical professionals would be able to successfully juggle their medical and military roles. Furthermore, despite suggesting that medical professionals faced with a dual loyalties conflict would have had a choice between which duties to discharge,[59] Howe has also argued that military necessity should be perceived as the

[53] Howe (n 9) 320.
[54] ibid.
[55] ibid.
[56] ibid.
[57] Sidel and Levy (n 9).
[58] Edmund G. Howe, 'New Biological Advances and Military Medical Ethics' in Robert Armstrong, Mark Drapeau, Cheryl Loeb et al. (eds.), *Bio-Inspired Innovation and National Security* (National Defence University: Washington DC, 2010) 9.
[59] Similarly, to Howe, Moskop suggests that medical and military duties may clash posing dual loyalties conflict and it would be up to the medical professional how to resolve such a conflict. John C. Moskop, 'A Moral Analysis of Military Medicine' (1998) 163 *Military Medicine* 76.

overriding objective.[60] Ultimately then, according to Howe, despite admitting a degree of choice and some flexibility that enables medical professional to juggle their roles, any dual loyalties conflict should be resolved in favour of military duties. This is a contradiction. Furthermore, it disregards the legal and medical professional norms that medical professionals are bound to adhere to.[61] Nonetheless, the proposal that duties towards the state will trump medical duties is not far removed from the views held by the US Administration.

Rascona, a physician in the military, like Howe rejects the position taken by Sidel and Levy and notes that medical professionals are necessary within the military and are bound by what he calls 'legitimate duty.'[62] He convincingly argues that the medical professionals' role in the military is 'simply to lessen the harm that will otherwise occur, with or without their participation.'[63] However, he ignores the issue of institutional loyalties, downplaying its relevance and suggesting that: 'obedience to command structure is more appropriately considered a logical requisite for military effectiveness, just as sterile technique is a logical requisite for safe surgical operations.'[64] While he correctly recognises that such obedience to command structure applies in cases of lawful orders only, he claims that 'obedience to questionable orders is more likely than not to bring an officer *trouble*, especially if such obedience conflicts with international law as found in the Geneva Conventions (for example, wanton destruction or breaching human rights of prisoners).'[65] The reference to 'trouble' is inadequate as an explanation of the consequence of the conduct.[66]

The timing of the above debate is of relevance, as it took place shortly before evidence of the use of EITs (and their extent) in American detention centres was brought to light. The evidence of medical

[60] Howe (n 9) 320. See also: Mark J. Osiel, *Obeying Orders: Atrocity, Military Discipline and Law of War* (Transaction Publishers: New Brunswick, 1999) 26. See also: Articles 90(2), 91(c)(4), and 92 of the US Uniform Code of Military Justice.
[61] This is elaborated upon in the next chapter.
[62] Dominic Rascona, 'The Moral Obligation of United States Military Medical Service' in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 320.
[63] ibid 321.
[64] ibid 322.
[65] ibid 322. [Emphasis added]. A soldier engaging in a manifest illegal order commits a crime and is subject to criminal accountability.
[66] See Section 4 below.

involvement in EITs tests the claims made by Sidel and Levy, Howe, and Rascona, exposing the flaws in their respective approaches. Sidel and Levy's position would have prevented medical professionals from becoming involved in EITs but would have denied the detainees the medical assistance they required. Howe's approach would have enabled medical professionals' involvement in EITs and disregarded the duties that medical professionals would normally have held to detainees as their patients, and so requiring them to do whatever was needed to secure the success of the mission. This is the closest to what actually happened in the detention centres. Rascona's position, while requiring medical professionals to adhere to the legitimate duty (legal duty), would have failed if the analysis of the legal duty was based on the analysis of domestic and international laws provided by the US Administration.[67]

Contrary to Howe and Rascona, this thesis argues that medical professionals' duties towards different parties must be adequately assessed and followed. If the legal and medical professional norms guiding medical and military action are coterminous or similar, no conflict will exist. This would then mean that if a medical professional were to follow orders requiring them to be involved in some form of conduct that contradicts such norms, such adherence would not be a consequence of military duties overriding conflicting medical duties, but would merely reflect institutional loyalties, which should properly have been disregarded. Institutional loyalty is a psychological construct and is not grounded in law.[68] By following institutional loyalties, medical professionals may find themselves in breach of law and their medical and military professional norms.

4. Contesting the Dual Loyalty Presumption in Cases of Criminal Conduct

Against the prevailing opinion in academic literature discussed above, there are good reasons to suggest that medical and military duties should not be considered as always and inevitably in conflict. Rather, a more nuanced, case-by-case analysis allows for the differentiation of cases where there is

[67] See Chapter Two.
[68] This dual loyalty conflict fiction is derived from the strong feeling of organisational loyalty or bureaucratic integration. Mehring (n 24) 393; Lifton (n 27) 415-416.

genuine conflict from other situations where no conflict exists. This section discusses the issue of medical and military duties in cases of involvement in criminal conduct, arguing that the similarities between the duties owed in such cases offer a strong foundation for determining that they are not in conflict.

Whether acting as a doctor or as a soldier, the use of EITs that may constitute criminal acts cannot be seen as compatible with the soldier's duties. Even though soldiers may feel an obligation to follow an order requiring them to be involved in acts which amount to criminal conduct such as torture, inhuman or degrading treatment or punishment, or other criminal conduct, as a consequence of the hierarchal chain of command, soldiers must disobey such orders as manifestly illegal. It is noteworthy that the US jurisprudence pertaining to the issue of manifest illegality goes even further and states that:

> the acts of a subordinate done in compliance with an unlawful order given him by his superior are excused and impose no criminal liability upon him unless the superior's order is one which a man of ordinary sense and understanding would, under the circumstances, known to be unlawful, or if the order in question is actually known to the accused to be unlawful.[69]

Ignorance of the law in pursuance of such manifestly illegal orders will not absolve soldiers from legal accountability for following them. However, it is accepted that the manifest illegality[70] of an order may be difficult to ascertain in certain cases, for example, because of the circumstances soldiers find themselves in (for example on the battlefield) or because of uncertainties about what the law

[69] *US* v *Calley* (1974) 48 C.M.R. 19, 27. See also: Osiel (n 36) 971.

[70] US Department of the Army, 'Field Manual 27-10. The Law of Land Warfare' (1956) 509: '[T]he fact that the law of war has been violated pursuant to an order of a superior authority... does [not] constitute a defence in the trial of an accused individual, unless he did not know and could not reasonably have been expected to know that the act ordered was unlawful.' According to Anderson, 'obedience to superior orders that are not permitted by the rules of war or that are 'clearly illegal' provides no excuse to an individual acting under those commands.' Ronald A. Anderson, *Wharton's Criminal Law and Procedure. Volume 1* (Lawyers Co-operative Pub. Co.: Rochester NY, 1957) 258 (as cited in Lydia Ansermet, 'Manifest Illegality and the ICC Superior Orders Defence' (2014) 47 *Vanderbilt Journal of Transnational Law* 1425).

requires them to do.[71] Indeed, in the case study of this thesis, the misinterpretation of what the law requires is created and upheld by the very government that authorised the unlawful acts.

Medical professionals embedded within a military hierarchical structure may consider themselves to be bound by obedience to a superior. This may affect their ability to follow and adhere to domestic and international law (without jeopardising the military hierarchy). In the case of criminal prosecutions, EITs were authorised by the state, which thereby sanctioned the involvement of medical professionals. As Osiel notes:

> the bureaucrat, by hypothesis, is subject to a unified chain of command imposing strict subordination upon him even as it bestows similar supervisory powers and duties over others. The regulations governing his activities are impersonal, consistent, and complete.[72]

The military hierarchy presupposes that soldiers obey orders believing they are lawful.[73] This quasi-blind obedience is often considered to be the backbone of the profession[74] and classified as a soldier's duty. For example, the obedience of soldiers to their military superiors may be rationalised not only by the strict requirements of military discipline but also by the possibility of misinterpretation of the law by the soldier.[75] Frederick Pollock, a jurist, goes even further to claim that a man becoming a soldier becomes the property of his superiors.[76] This suggests that a soldier would not have the freedom to disobey or vary an order but must follow it in its entirety. This position is no longer supported in law (whether US domestic or international).

Such blind obedience among medical professionals in the military would be problematic in itself, but even more so as medical professionals are bound by fiduciary duties towards their patients. While

[71] Also, worth noting that in the case study of the thesis, the US Administration continued to challenge the argument that EITs amounted to torture, including in legal memoranda.
[72] Mark J. Osiel, *Making Sense of Mass Atrocity* (Cambridge University Press: New York, 2009) 95.
[73] ibid 1.
[74] ibid 1.
[75] Osiel (n 36) 971.
[76] Frederick Pollock, 'The Works of the League of Nations' (1919) 35 *Law Quarterly Review* 193, 198.

they may owe duties towards others that sometimes conflict with their fiduciary duties, as discussed above, this does not mean that they should abandon their fiduciary duties.[77] Furthermore, military obedience to one's superiors is not absolute, and particularly not when the actor is asked to engage in criminal conduct. Indeed, medical professionals acting as doctors or as soldiers are prohibited from engaging in criminal acts.[78] Furthermore, and despite the military hierarchy requiring soldiers to follow orders from a superior, the law equips soldiers with limited discretion to decide whether to follow an order, including when the order is manifestly illegal.[79] This suggests that military medical professionals, whether acting as doctors or soldiers, can disobey manifestly illegal orders.[80] Nonetheless, at the same time, the US law[81] provides defences that may encourage adherence to illegal orders. For example, when following orders may be justified with the defence of superior order.[82] Ultimately, a soldier's decision whether to obey or not to obey an order may be justified. Such an approach means impunity, in that soldiers may avoid being held accountable for their actions

[77] See: Chapter Six where the thesis argues that in a case of a genuine conflict of dual loyalties, the fiduciary duties should prevail.
[78] See above.
[79] Osiel (n 72) 5. Yoram Dinstein, *The Defence of 'Obedience to Superior Orders' in International Law* (Oxford University Press: Oxford, 2012) 26; Frederick Herbert Maugham, *United Nations Organisations and the War Crimes* (Greenwood Press,1951) 48.
[80] Osiel (n 36) 971. However, as Osiel claims 'where a soldier must exercise situational judgment in order to ascertain the unlawfulness of a superior's order, that order is not manifestly illegal.'
[81] See for example: The United States Department of the Army Field Manual (the 1956 The Law of Land and Warfare), para. 509(a): 'The fact that the law of war has been violated pursuant to an order of a superior authority, whether military or civil, does not deprive the act in question of its character of a war crime, nor does it constitute a defense in the trial of an accused individual, unless he did not know and could not reasonably have been expected to know that the act ordered was unlawful. In all cases where the order is held not to constitute a defense to an allegation of war crime, the fact that the individual was acting pursuant to orders may be considered in mitigation of punishment.' Also: The Air Force Pamphlet International Law - The Conduct of Armed Conflict and Air Operations, 19 November 1976, 15/5–15/6; The US Navy, The Commander's Handbook on the Law of Naval Operations (1995), 6/4–6/5. See also the international criminal law approach under the Rome Statute. Article 33(1) of the Rome Statute: 'The fact that a crime within the jurisdiction of the Court has been committed by a person pursuant to an order of a Government or of a superior, whether military or civilian, shall not relieve that person of criminal responsibility unless: (a) The person was under a legal obligation to obey orders of the Government or the superior in question; (b) The person did not know that the order was unlawful; and (c) The order was not manifestly unlawful.' However, as per Article 33(2), 'For the purposes of this article, orders to commit genocide or crimes against humanity are manifestly unlawful.'
[82] Henry Donnedieu de Vabres, 'The Nuremberg Trial and the Modern Principles of International Criminal Law' in Guenael Mettraux (ed.), *Perspectives on the Nuremberg Trial* (Oxford University Press: New York, 2010) 268. Joseph B. Keenan and Brendan F. Brown, *Crimes Against International Law* (Public Affairs Press: Washington, 1950) 131; Hans Kelsen, *Peace Through Law* (The University of North Carolina Press: Chapel Hill, 1944) 104; Hans Kelsen, 'Collective and Individual Responsibility in International Law with particular Regard to the Punishment of War Criminals' 31 *California Law Review* (1942-1943) 556; Erik Castren, *The Present Law of War and Neutrality* (Annales Academiae Scientiarum Fennicae: Helsinki, 1954) 88; Hersch Lauterpacht and Lassa Oppenheim, *International Law: A Treatise. Vol. II. Disputes, War, and Neutrality* (Longmans, Green, and Co.: New York, 1952) 569; Franz B. Schick, 'The Nuremberg Trial and the Development of an International Criminal Law' (1947) 59 *Juridical* Review 198.

whether they obey or disobey the order. However, this will depend on the order. Understandably, here, the question would be whether the existence of the legal opinions prevents the order from being considered manifestly illegal; alternatively, whether any other defences would be available.

The issue of a reasonably held mistake is also of significance in the case of medical professionals. While medical professionals are assumed to know and adhere to the laws that apply to them, they may not be clear what those laws require them to do in all circumstances. Indeed, Diane E. Hoffmann, professor of law, finds that, ordinarily, there is a tendency among medical professionals to 'over-comply with the law, e.g., the law's complexity and uncertainty, the fact that they misunderstand the law, or the possibility that they have unique personal characteristics that make them more sensitive (i.e. risk-averse) to entanglements with the law.'[83] She further suggests that:

> physicians may intentionally or knowingly break the law because they believe it is in their patient's best interest to do so or because such action is consistent with their professional norms. They perceive complying with the law as breaching their duty to their patients as well as violating their autonomy and contravening their judgments as to what is the right thing to do… In these cases, physicians are not complying with the law because they disagree normatively with its requirements.[84]

This is an important consideration for this thesis' case study. The argument would then be that the lack of understanding of the law or of the authority of the legal opinions that justified the use of EITs (discussed in Chapter Two) may have contributed to the understanding that the involvement in EITs was legal and in accordance with medical norms.[85] The issue then raises the questions whether medical professionals could be held to account where they reasonably relied on the legal opinions.

[83] Diane E. Hoffmann, 'Physicians Who Break the Law' (2009) 53 *Saint Louis University Law Journal* 1049, 1064.
[84] ibid 1050.
[85] Even if such reliance was unreasonable (and hence unlawful), the concerning conclusion may be that medical professionals considered such involvement as in the detainees' best interest, as they chose to become involved. Alternatively, this may mean that they considered their involvement being in the patient's best interest as opposed to when the CIA or other actors were to be involved.

The situation would be further exacerbated by the existence of the institutional loyalties that ultimately distort a medical professional's understanding of and ability to adhere to their duties.

This section discusses the stages of the taxonomy that may constitute complicitous acts to EITs (as secondary liability) but which may also constitute criminal conduct for which doctors may potentially owe primary liability.[86] This includes cases where medical professionals develop new or alter existing EITs (stage three), falsify evidence of the use of EITs (stage five), treat injuries to facilitate further use of EITs (stage six), advise on and tailor EITs to a specific detainee (stage seven), and directly participate in EITs (stage ten).

4.1. Falsifying Evidence of the Use of EITs

Stage five includes cases where medical professionals actively falsify evidence of EITs, the cause of any injuries recorded, and any other relevant medical data. Such falsification may amount to a crime and trigger criminal (as well as civil and disciplinary) accountability. As discussed in Chapter One, medical professionals have, generally, underreported the medical conditions or injuries of detainees.[87] Here, independent of the nature of the EIT being recorded (whether as criminal or non-criminal conduct), falsifying the evidence is a criminal act in its own right.[88]

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[86] See Chapter One.
[87] See Chapter One, Section 2.2. PHR Report.
[88] Falsifying medical data may fall within the purview of Article 241 of the Model Penal Code that deals with falsification in official matters.
§241.3 of the Model Penal Code defines unsworn falsification to authorities as follows:
'(1) In General. A person commits a misdemeanour if, with purpose to mislead a public servant in performing his official function, he:
(a) makes any written false statement which he does not believe to be true; or
(b) purposely creates a false impression in a written application for any pecuniary or other benefit, by omitting information necessary to prevent statements therein from being misleading; or
(c) submits or invites reliance on any writing which he knows to be forged, altered or otherwise lacking in authenticity…
(2) Statements "Under Penalty." A person commits a petty misdemeanour if he makes a written false statement which he does not believe to be true, on or pursuant to a form bearing notice, authorized by law, to the effect that false statements made therein are punishable.
(3) Perjury Provisions Applicable. Subsections (3) to (6) of Section 241.1 apply to the present Section.'
§241.7 of the Model Penal Code defines tampering with or fabricating physical evidence as:
'A person commits a misdemeanour if, believing that an official proceeding or investigation is pending or about to be instituted, he:
(1) alters, destroys, conceals or removes any record, document or thing with purpose to impair its verity or availability in such proceeding or investigation; or

The duty to record and maintain medical data is enshrined in state law regulations on clinical records.[89] Medical professionals acting as soldiers are also subject to similar duties to record (medical) data. Indeed, soldiers are obliged to prepare comprehensive reports on their activities.[90] The Army Field Manual contains different reporting requirements depending on the situation and a special document that needs to be completed for the reporting of enemy and prisoners of war.[91] Once the duty to record data relating to EITs is established, under Article 107 of the Uniform Code of Military Justice (UCMJ), soldiers are under a duty to produce such data truthfully. Article 107 of the UCMJ states that:

> any person … who, with intent to deceive, signs any false record, return, regulation, order, or other official documents, knowing it to be false, or makes any other false official statement knowing it to be false, shall be punished as a court-martial may direct.[92]

(2) makes, presents or uses any record, document or thing knowing it to be false and with purpose to mislead a public servant who is or may be engaged in such proceeding or investigation.
§241.8 of the Model Penal Code defines tampering with public records or information.
(1) Offense Defined. A person commits an offense if he:
(a) knowingly makes a false entry in, or false alteration of, any record, document or thing belonging to, or received or kept by, the government for information or record, or required by law to be kept by others for information of the government; or
(b) makes, presents or uses any record, document or thing knowing it to be false, and with purpose that it be taken as a genuine part of information or records referred to in paragraph (a); or
(c) purposely and unlawfully destroys, conceals, removes or otherwise impairs the verity or availability of any such record, document or thing.
(2) Grading. An offense under this Section is a misdemeanour unless the actor's purpose is to defraud or injure anyone, in which case the offense is a felony of the third degree.'

[89] See: State Regulations Pertaining to Clinical Records. For example, In Massachusetts, Section 150.013 (c) states that: '(C) All records shall be complete, accurate, current, available on the premises of the facility for inspection and maintained in a form and manner approved by the Department. The following records shall be maintained: (1) Daily census. (2) Employee records on all employees. (3) Patient care policies. (4) Incident, fire, epidemic, emergency and other report forms. (5) Schedules of names, telephone numbers, dates and alternates for all emergency or "on call" personnel. (6) A Patient or Resident Roster approved by the Department…' In Kansas, Section 28-39-163 (m) states that: '(1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices. The records shall meet the following criteria: (A) Be complete; (B) be accurately documented; and (C) be systematically organized.' In South Dakota, according to Section 44:04:09:02 states that 'There must be an organized medical record system. A medical record must be maintained for each level of care for each patient or resident admitted to the facility.'
[90] See: US Army Report and Message Formats, Field Manual 101-5-2.
[91] ibid. Report No. E030 is designed for reporting of enemy and prisoners of war. The report contains information on the required medical care and/or transfer to the combat health staff chains or medical evaluation, a summary of incidents, assessment, and any extra narrative.
[92] Article 107 of the UCMJ.

This means that falsifying evidence of the use of EITs would be a breach of the soldier's duty to record data.

While the duty to record medical data is unproblematic *per se*, a more difficult question is which data would medical professionals be obliged to record as medical data, and to what extent this includes data on the use of EITs,[93] given the various activities that medical professionals undertake in American detention centres. The Instruction and other documents, such as the Army Field Manual, are silent on the issue. It may be assumed that the lack of any express direction in the Instruction means that medical professionals were to apply norms as a default, with only the detainees' medical conditions, including injuries (or other effects of EITs), constituting medical data that must be recorded. However, there is also a strong argument that information on the EITs used, where available, must be recorded as ultimately it explains the origin and nature of any injuries suffered.

Given what is known about the organisation of detention centres, it is reasonable to assume that ordinary medical professionals would be the main actors responsible for recording the medical data of detainees, as this derives from the role foreseen for them in the detention centres, and they would have been under a duty to record any medical information about the detainees' medical conditions and injuries, and treatment received. They would also have been under a duty to record any mistreatment or injuries described to them by detainees or observed themselves.[94] Furthermore, they would also have been under a duty to record their suspicions if they had reasonable grounds to believe that a patient was subjected to abuse.[95] Additionally, recording the data incorrectly and in a way that conceals the nature and origin of the injuries, in itself, may constitute a peril to the lives and health of the detainee, and thus fall within the purview of the offence of recklessly endangering another.[96]

[93] Ordinarily, medical professionals are obliged to record all relevant information regarding patient's conditions, injuries, and treatment. The statutory requirements will vary between states. See: State Regulation Pertaining to Clinical Records.
[94] See: State Regulations Pertaining to Clinical Records.
[95] ibid.
[96] See: §211.2 of the MPC on recklessly endangering another.

As BSCs had very limited or no contact with the detainees,[97] the cases where they could record medical data would be limited, for example, to cases when BSCs monitored the use of EITs (stage two of the taxonomy) or when they provided emergency treatment (stages one and six). In those cases, BSCs may have likewise been under a duty to record the EITs used and their effect upon the detainees. However, here, BSCs would generally be recording this data for their own purposes – to analyse the effectiveness of EITs and assist in adjusting future EITs – and this is different from completing medical records. Only in cases of emergencies, they would be under the duty to record the medical data.

As such, all medical professionals in American detention centres would be under a duty to record medical data, independent of the role they undertake, although in the case of BSCs, limited to emergencies only. Failing to do so would constitute a breach of duty. The medical professionals recording medical data would have been under a duty to do so truthfully and accurately. Recording the data incompletely or incorrectly would constitute a breach of their duty. Failing to record, and recording medical data incorrectly constitutes criminal offences. This suggests that since medical professionals, independent of their role in detention centres, are under a duty to record relevant information regarding the use of EITs and record it truthfully and accurately, there would not be any conflict of dual loyalties that would justify them in falsifying the medical data. The medical professionals engaged in falsifying evidence of the use of EITs could not rely on the dual loyalties' argument.

4.2. Treating Injuries to Facilitate Further Use of EITs

Generally, the provision of basic medical care to detainees will be lawful where it is in accordance with medical professional norms, including the obligation to act in the best interest of the patient.[98] The duty to act in the best interest of the patient (detainee), at minimum, also means following the

[97] See: Instruction (n 3) E2.1
[98] This is discussed further in Chapter Six.

law and medical professional norms and abstaining from any practices that are contrary to these standards.[99] Nonetheless, the issue is very complex in the case of American detention centres, providing the detainees with medical care would also render them fit for further EITs, potentially facilitating criminal conduct. This distinguishes medical intervention in detention centres from many other law enforcement contexts, such as police stations, where medical professionals are tasked with providing care and assessing and ensuring that detainees are fit for questioning.[100] Here, the act of determining whether detainees are 'fit for further interrogation' means authorising further pain or suffering. This conflicts with the medical professionals' duty to act in the best interest of their patients.[101] Hence, it is not the examination of a detainee's fitness for interrogation that changes the dynamics of the doctor-patient relationship, but the fact that subsequent interrogation will happen. This is what may pose a dual loyalties conflict. The mere possibility that a detainee could be subjected to further interrogation using EITs may not be enough to pose a dual loyalties conflict by itself.[102] Nonetheless, the distinction is artificial in this context.

While this thesis differentiates the provision of basic medical care (stage one) and the provision of medical care that facilitates EITs (stage six), from the perspective of the medical professional, Chiara Lepora and Joseph Millum, medical professional and ethicist respectively, propose a different distinction based on the request to provide medical assistance. They draw a distinction between medical care requested by the detainee and that requested by the interrogator.[103] While this distinction appears helpful, there are further considerations that it neglects, including whether the detainee was

[99] Beauchamp and Childress (n 38) 12.
[100] Paul Lauritzen, *The Ethics of Interrogation: Professional Responsibility in an Age of Terror* (Georgetown University Press: Washington DC, 2013); US Department of the Army, 'US Army Human Intelligence Collector Field Manual' (2014) 108, 5-91. See also: BMA Ethical Decision-Making for Doctors in the Armed Forces: A Toolkit; APA Presidential Task Force, Psychological Ethics and National Security (2005). See also: APA Presidential Task Force, Psychological Ethics and National Security (2005); Jean-Pierre Restellini and Romeo Restellini, 'Prison-Specific Ethical and Clinical Problems' in Stefan Enggist, Lars Møller, Gauden Galea and Caroline Udesen (eds.), *Prisons and Health* (World Health Organization: Copenhagen, 2014) 11; Marc Shalit and Matthew R. Lewin, 'Medical Care of Prisoners in the USA' (2004) 364 *The Lancet Special Issue* 34.
[101] Vincent Iacopino and Stephen N. Xenakis, 'Neglect of Medical Evidence of Torture in Guantanamo: A Case Series' (2011) *8 PLoS Medicine* 3; Amnesty International, 'Doctors and Torture' (2002) 2; Restellini and Restellini (n 100) 11; Shalit and Lewin (n 100) 34–35.
[102] See: Model Penal Code §2.02 Mens Rea Terms. This will be discussed further in the next chapter. Under stage one of providing basic medical care, the facilitation of EITs is a possibility.
[103] Chiara Lepora and Joseph Millum, 'The Tortured Patient: A Medical Dilemma' (2011) 41 *Hastings Centre Report* 41.

able to give informed consent to the treatment or if they had the capacity to do so. Furthermore, the proposal avoids considering whether the detainee knew that his medical treatment would be followed by EITs. Indeed, it is questionable whether medical professionals would have been able to obtain informed consent from detainees to provide treatment if detainees were aware of what was to follow. It is possible that with knowledge of subsequent interrogation, some detainees may choose not to be treated. As Lepora and Millum claim, any medical professional who fulfils his or her professional obligation to provide care and facilitates further interrogations is also complicit in them. Sometimes, 'the right thing for a doctor to do requires complicity in torture.'[104]

According to Lepora and Millum, the provision of medical care is ethically right, even if by doing so medical professionals are involved in EITs.[105] This may be correct in certain situations: often there may be little if any difference between providing medical care and facilitating criminal conduct by virtue of the activities undertaken. However, there are legal and ethical considerations that should not be generalised and overlooked. It is clear from the ten stages taxonomy introduced in Chapter One, that not all conduct is alike. Nonetheless, the extraordinary challenge medical professionals may face in such a case would be whether their duty towards the detainees (patients) would be to provide care and so ease the pain and suffering (thereby also allowing further interrogation to take place) or refuse to provide care, allowing suffering to continue but potentially preventing further interrogation from taking place (which could be in the best interest of the detainees as patients). This is not a dual loyalty conflict. Here, the medical professionals would need to identify what is in the best interest of the detainee as patient, deciding between the two options. They are unlikely to have the option of providing help, easing the pain or suffering, and disallowing further interrogation as this is outside of their decision-making capability.[106]

[104] ibid 38.
[105] ibid.
[106] Alberto Jadresic, 'Doctors and Torture: An Experience as a Prisoner' (1980) 6 *Journal of Medical Ethics* 124.

Others, for example, Fritz Allhoff, professor of philosophy, claim that 'traditional medical values mandate, as opposed to forbid, at least minimal physician participation in hostile interrogations.'[107] This argument is difficult to align with current medical professional standards. It is accepted that destructive or harmful practices may sometimes be justified, for example, removing limbs to save the life of a patient. These must be distinguished from involvement in criminal conduct, and especially torture. Nonetheless, some forms of involvement, such as treating interrogation injuries, providing treatment for patients' pre-existing conditions, intervening during prolonged interrogation or using their medical skills to determine detainees' fitness for surviving interrogation have been recognised as permissible.[108] However, they raise a dual loyalty issue: whether such acts are in the best interest of the patient or of the state (or the institution).

Indeed, under stage six, the provision of basic medical care that facilitates EITs may amount to criminal conduct. Engaging in this stage may also fundamentally contradict the best interest of the detainee (as the patient). Ultimately, the focus of the doctors' work is EIT-centred (attempting to make EITs safe, legal, and effective) and not patient-centred. Hence, while providing medical assistance may follow the medical duty of not allowing the detainee to die in detention, at the same time it may not be in the best interest of the detainee as it would facilitate further EITs (and so be contrary to the medical duties). Soldiers' duties in such a scenario would have been to provide medical assistance and treatment to the injured with this obligation being enshrined in customary international humanitarian law[109] and also in US domestic law.[110] However, one would then need to distinguish

[107] Fritz Allhoff, 'Physician Involvement in Hostile Interrogations' (2006) 15 *Cambridge Quarterly of Healthcare Ethics* 392.
[108] International Committee of the Red Cross, 'Report on the Treatment of Fourteen "High Value Detainees" in CIA Custody' (2007) 21.
[109] For example, Article 6 of the 1864 Geneva Convention states that 'Wounded or sick combatants, to whatever nation they may belong, shall be … cared for.' See also: Common Article 3 of the 1949 Geneva Conventions; Article 15, first paragraph, of the 1949 Geneva Convention I; Article 12, second paragraph, Article 18, first paragraph; Article 21, first paragraph of the 1949 Geneva Convention II, and Article 16, first paragraph, of the 1949 Geneva Convention IV.
[110] The 1956 US Field Manual states that 'Members of the armed forces and other persons… who are wounded or sick, shall be respected and protected in all circumstances. They shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected to torture or biological experiments; they shall not wilfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.' US Department of the Army, 'Field Manual 27-10. The Law of Land Warfare' (1956). Article 12 of the

between facilitating criminal conduct such as battery and facilitating torture. Where the medical professionals' involvement was to facilitate torture, they would have been under an obligation to abstain from such conduct. Where the criminal conduct constitutes torture, the duties would have been aligned prohibiting the medical professional's involvement. Under stage six, which constitutes an act facilitating EITs constituting criminal conduct but not torture, the duties would clash posing a dual loyalties conflict.

4.3. Developing New and Altering Existing EITs and Advising on and Tailoring EITs to a Detainee

Stage three, where medical professionals develop new or alter existing EITs, and stage seven, where they advise on and tailor EITs to a specific detainee, involve similar conduct and are considered together. It might be argued that the general tailoring of EITs (stage three) aims to improve the efficiency of the interrogation, potentially making EITs safer and, as such, is in accordance with the medical professionals' duties to act in the best interests of the detainees. Likewise, it might be suggested that tailoring EITs to cause more intense pain but thereby shortening the amount of exposure is in the best interest of the detainees (in comparison to EITs without the changes introduced by the medical professionals). Ultimately, this is a question of fact, however, it is difficult to concede that rendering an interrogation more efficient by virtue of causing more intense pain and suffering might be judged to be in a detainee's best interests.

Advising on and tailoring EITs (that amount to criminal conduct) for a specific detainee (stage seven), is highly likely contrary to the legal and medical professional norms doctors are bound by. Such involvement in criminal activities would also be contrary to the duties of medical professionals acting as soldiers, since soldiers are obliged to adhere to the laws that prohibit the use of torture and other

Geneva Convention I is incorporated in the US Air Force Pamphlet (1976) and the US Instructor's Guide (1985). The US Manual on Detainee Operations (2008) requires that 'all Department of Defence personnel and contractors will apply, without regard to a detainee's legal status, at a minimum, the standards articulated in Common Article 3 to the Geneva Conventions of 1949 and those standards found in Enclosure 4 to DoD 2310.01E.' US Armed Forces, 'Joint Chief of Staff United States Manual on Detainee Operations' (2008). However, this cited section on the treatment and protection of detainees is removed from the 2014 updated version of the document.

criminal acts.[111] Indeed, where soldiers believe that the activity they are ordered to undertake is manifestly illegal, independent of the potential benefit to the mission, they are required to disobey it.[112] Therefore, both medical and military duties are in accord, requiring the medical professionals to not engage, no conflict of dual loyalties occur.

4.4. Directly Participating in EITs

Finally, when it comes to direct participation in EITs (stage ten) that amounts to torture or other criminal acts, it is difficult to see how either doctors or soldiers owe any duty that might justify such participation. Again, medical professionals, whether acting in their medical or military capacity, are prohibited from actively participating in criminal acts.[113] As noted, where soldiers believe that the activity that they are ordered to undertake is manifestly illegal, they must disobey the order.[114] Similarly, soldiers are obliged to adhere to the law that prohibits the use of torture and other criminal acts. For example, the US Department of Defence Directive 2310.01E confirms that all detainees should be treated humanely.[115] This directive applies to all US Department of Defence personnel (and contractors), in all armed conflicts, and does not make a distinction based on the nature of the subject (whether lawful or unlawful combatant) or location of the detention centre.[116] Similarly, it makes no

[111] For example, 'Inhumane treatment of detainees is prohibited by the Uniform Code of Military Justice, domestic and international law, and [Department of Defence] policy. There is no exception to this humane treatment requirement. Accordingly, the stress of combat operations, the need for intelligence, or deep provocation by captured and/or detained personnel does not justify deviation from this obligation.' US Armed Forces, 'Joint Chief of Staff United States Manual on Detainee Operations' (2008) vii. Furthermore, 'Detaining officials must recognise that detained [enemy combatants] who have not satisfied the applicable criteria in the … [1949 Geneva Convention III] will have a status as unlawful [enemy combatants], but are still entitled to humane treatment. The inhumane treatment of detainees is prohibited and is not justified by the stress of combat or deep provocation.' US Armed Forces, 'Joint Chief of Staff United States Manual on Detainee Operations' (2008) I-4. See also: The 1956 US Field Manual: 'In no case shall disciplinary penalties be inhuman, brutal or dangerous for the health of internees.' US Department of the Army, 'Field Manual 27-2. The Law of Land Warfare' (1956). The 1980 US Air Force Commander's Handbook prohibits 'torture, threats, or other coercion against prisoners of war to obtain further information.' US Department of the Air Force, 'Air Force Pamphlet 110-34, Commander's Handbook on the Law of Armed Conflict (1980) 1-3(a)(2). The 1984 US Soldier's Manual and the 1985 Instructor's Guide indicate that no physical or mental torture (or coercion) may be inflicted on detainees. US Department of the Army, 'Field Manual 27-2. The Law of Land Warfare' (1956) 5; US Department of the Army, 'Instructor's Guide - The Law of War (1985) 10.

[112] Osiel (n 72); Dinstein (n 79) 26.

[113] Furthermore, when acting in their medical capacity, even where the medical professionals are authorised to provide medical care, providing treatment that is different from the treatment covered by informed consent would amount to battery (as criminal conduct). *Berkey* v *Anderson* (1969) 1 Cal. App. 3d 790, 803 [82 Cal. Rptr. 67]; *Pedesky* v *Bleiberg* (1967) 251 Cal. App. 2d 119, 123 [59 Cal. Rptr. 294].

[114] Osiel (n 72) 5.

[115] US Department of Defence Directive 2310.01E, 3 (b).

[116] Instruction (n 3) 4.1.

distinction between soldiers and medical professionals. Furthermore, even if detainees in American detention centres were not covered by the Geneva Conventions, international law protections, including human rights law, still apply, and soldiers or medical professionals are required to adhere to the law that applies to them. Considering the above, there would be no dual loyalties conflict and medical professionals would be under a duty not to engage.

5. Conclusion

Most of the literature accepts that, in certain situations, medical professionals face dual loyalties conflicts that would affect their duties towards their patients. Such dual loyalties may limit the way medical professionals would be able to discharge their duties towards their patients, however, they would not automatically trump them. Only in an extremely limited number of cases, is it likely that duties owed towards detainees as patients would need to be abandoned altogether. This chapter has shown, in cases of criminal conduct, that there will be no dual loyalties conflict, apart from in a very limited number of cases, for example, stage six. However, even in those cases, the conflict will occur only where the criminal conduct does not amount to torture. The conflict should not be accepted as given as the duties are coterminous. As such, an order to be involved or facilitate criminal conduct should be refused. In the majority of the cases discussed, medical and military duties are not in conflict and no duty would require either doctors or soldiers to choose and/or prioritise the involvement in criminal acts. Otherwise, dual loyalties would facilitate engagement in criminal conduct and the doctrine cannot be used as such. As explained in this chapter, as a matter of law in the case of criminal conduct, soldiers have duties that are often broadly aligned with the duties that medical professionals have towards their patients. In cases of criminal conduct, the dual loyalties argument would not be relevant as the duties of doctors and soldiers would be aligned requiring medical professionals to refrain from engaging in such acts.

However, a dual conflict may arise with regard to some other forms of non-criminal conduct, including involvement which may be subject to civil or disciplinary liability. This then raises the issue

of which duty should be followed, which is considered in the next chapter. The next chapter considers the different duties that military medical professionals have in their dealings with detainees and asks the crucial question of whether these duties conflict and, if so, how they can be resolved.

CHAPTER SIX: Addressing the Dual Loyalties Conflict in Cases of Non-Criminal Conduct

1. Introduction

Although most of the literature on the topic of dual loyalties theorises that in the case of military doctors, medical and military obligations may come into conflict,[1] Chapter Five made a compelling case that this is not always inevitably so. Rather, a more nuanced analysis permits the differentiation of genuine cases of conflict from cases where the duties are aligned. This chapter moves on to consider cases of non-criminal conduct, analysing the duties that medical professionals owe as doctors and as soldiers in order to explore whether such non-criminal involvement may result in *prima facie* civil and disciplinary accountability, and the role of dual loyalties in blocking any such liability. It will then consider both cases where the duties of soldiers and medical professionals are again closely aligned, and cases where there may be a genuine conflict of dual loyalties. This thesis will argue that even in these latter cases, it should not be assumed that this serves to exclude liability. Rather there are good reasons for believing that fiduciary duties may require medical professionals to abandon other, non-fiduciary duties.

This chapter thus focuses on conduct that may fall short of the threshold of criminal acts but would nonetheless attract civil or disciplinary liability, namely, on stages where medical professionals provide basic medical care, monitor the use of EITs, misuse of detainees' medical data for EITs, force-feeding, and withdraw or withhold basic medical care. It analyses the concurring duties that medical professionals may owe as doctors and as soldiers and identifies whether the dual loyalties conflict occurs (Section 2). It concludes that only in exceedingly rare cases of minor involvement can the dual loyalties argument play a role in exculpating doctors from civil or disciplinary accountability

[1] Victor W. Sidel and Barry S. Levy, 'Physician-Soldier: A Moral Dilemma' in Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 296; Edmund G. Howe, 'Point/Counterpoint--A response to Drs Sidel and Levy (Physician-Soldier: A Moral Dilemma)' in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 320; Leslie London, Leonard S. Rubenstein, Laurel Baldwin-Ragaven, and Adriaan Van Es, 'Dual Loyalty among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict' (2006) 15 *Cambridge Quarterly of Healthcare Ethics* 381.

(Section 3). In those exceptional cases where a dual loyalties conflict does arise, this thesis challenges the argument that military duties would override fiduciary duties. It argues that a claim of dual loyalties will rarely serve to justify or excuse unlawful behaviour, as in most cases where a conflict exists, the fiduciary duty owed by a doctor to their patients would prevail.

2. Medical Professionals' Duties in American Detention Centres

This section focuses on those forms of conduct which are unlikely to attract criminal liability, unless in exceptional circumstances, but may be culpable in other ways. This section considers the stages of the taxonomy relating to the provision of medical care first (stage one), followed by the stages where medical care is withheld or withdrawn (stage nine) or where medical professionals are providing medical care without the detainees' consent, such as force-feeding (stage eight). This is followed by an analysis of stage two of monitoring EITs and stage four where the medical professionals misuse detainees' medical data for EITs.

2.1. The Provision of Care and Withdrawing Treatment

2.1.1. Providing Basic Medical Care

Ordinarily, providing basic medical care to detainees will involve acting in their best interest, alleviating pain or suffering, preventing the deterioration of symptoms, preventing further injuries or death, or other similarly beneficent concerns.[2] Ensuring that detainees are fit for interrogation, in itself, is a standard duty that medical professionals have to fulfil in the law enforcement contexts,[3] for example at police stations or hospitals before detainees are interviewed.[4] However, for the

[2] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (Oxford University Press: New York, 2001) 6-10. However, see the analysis of stage six in Chapter Five, Section 4.2.
[3] Paul Lauritzen, *The Ethics of Interrogation: Professional Responsibility in an Age of Terror* (Georgetown University Press: Washington DC, 2013); US Department of the Army, 'US Army Human Intelligence Collector Field Manual' (2014) 108, 5-91. See also: BMA Ethical Decision-Making for Doctors in the Armed Forces: A Toolkit; APA Presidential Task Force, Psychological Ethics and National Security (2005).
[4] Jean-Pierre Restellini and Romeo Restellini, 'Prison-Specific Ethical and Clinical Problems' in Stefan Enggist, Lars Møller, Gauden Galea and Caroline Udesen (eds.), *Prisons and Health* (World Health Organization: Copenhagen, 2014) 11; Marc Shalit and Matthew R. Lewin, 'Medical Care of Prisoners in the USA' (2004) 364 *The Lancet Special Issue* 34.

provision of any medical care to be lawful and in accordance with professional ethical codes of practice, it must be provided with the patient's (detainee's) consent, whether by way of an express (informed) consent when possible or by way of implied consent in emergencies that render the detainee unable to provide consent.[5] Indeed, consent underpins the relationship between medical professionals and patients.[6] Cases where the detainee (patient) is unconscious (in an emergency) or lacking capacity for any other reasons are the only instances where basic medical care can be provided without consent.[7] These emergency situations will be contrasted with force-feeding of detainees (stage eight).

The provision of basic medical care under stage one would fulfil military medical duties towards detainees, as military medical professionals are required to provide medical assistance and treatment to those who are injured.[8] This obligation exists under customary international humanitarian law[9] and is also reflected in US domestic law.[10] Hence, the provision of basic medical care to detainees would not pose a dual loyalties conflict as the duties owed by a doctor and by a soldier would align. Again, this would only be where the detainee provided informed consent or where consent is implied (in

[5] *Wheeler* v *Barker* (1949) 92 Cal. App. 2d 776, 785 [208 P.2d 68]; *Preston* v *Hubbell* (1948) 87 Cal. App. 2d 53, 57-58 [196 P.2d].

[6] AMA Code of Medical Ethics Opinion 2.1.1. See also: *Bouvia* v *Superior Court* (1986) 225 Cal. Rptr. 297; *Cobbs* v *Grant* (1972) 8 Cal. 3d. 229, 242; 104 Cal. Rptr. 505; 502 P. 2d. 1.

[7] Where the detainee is unconscious, the consent would be assumed, unless there is evidence to suggest that the detainee did not allow such medical assistance.

[8] Daniel Messelken, 'Conflict of Roles and Duties - Why Military Doctors are Doctors' (2015) 1 Ethics and Armed Forces 44; Edmund G. Howe, 'Dilemmas in Military Medical Ethics Since 9/11' (2003) 3 *Kennedy Institute of Ethics Journal* 175; Michael L. Gross, 'Bioethics and Armed Conflicts. Mapping the Moral Dilemmas of Medicine and War' (2004) 6 *Hasting Centre Report* 29.

[9] For example, 'Wounded or sick combatants, to whatever nation they may belong, shall be … cared for.' Article 6 of the 1864 Geneva Convention. See also: Common Article 3 of the 1949 Geneva Conventions; Article 15, first paragraph, of the 1949 Geneva Convention I, Article 12, second paragraph, Article 18, first paragraph, Article 21, first paragraph of the 1949 Geneva Convention II, and Article 16, first paragraph, of the 1949 Geneva Convention IV.

[10] 'Members of the armed forces and other persons… who are wounded or sick, shall be respected and protected in all circumstances. They shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected to torture or biological experiments; they shall not wilfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.' US Department of the Army, 'Field Manual 27-10. The Law of Land Warfare' (1956). Article 12 of the Geneva Convention I is incorporated in the US Air Force Pamphlet (1976) and the US Instructor's Guide (1985). The US Manual on Detainee Operations (2008) requires that 'all Department of Defence personnel and contractors will apply, without regard to a detainee's legal status, at a minimum, the standards articulated in Common Article 3 to the Geneva Conventions of 1949 and those standards found in Enclosure 4 to DoD 2310.01E.' US Armed Forces, 'Joint Chief of Staff United States Manual on Detainee Operations' (2008).

emergencies). However, where medical professionals provide medical care without consent, it may be possible to talk about a conflict of dual loyalties. Where the detainee has the capacity to provide informed consent but refuses to do so and refuses treatment, the medical professional who treats him without consent would do so in breach of his medical duties, but arguably, in accordance with his military duties to prevent the detainee from dying in detention.[11] This would manifest as a dual loyalty conflict.

2.1.2. Withholding or Withdrawing Basic Medical Care

Withholding or withdrawing medical care (stage nine of the taxonomy) is not a recognised EIT, however, it may have been used as such. This is suggested in the evidence discussed in Chapter One. Generally, there will be scenarios where medical professionals may not be under a duty to provide medical care or will be limited in their duty to do so, whether by law, ethical considerations, resources or for other reasons.[12] Therefore, the analysis here focuses only on cases where medical professionals are under a duty to provide basic medical care and intentionally withdraw or withhold it from detainees as a form of punishment and/or inducement into co-operating with an interrogator. Where medical professionals are under a duty to provide medical care, it would be both unlawful and contrary to medical professional norms to refuse to provide detainees with basic medical care.[13] Withdrawing or withholding medical care to punish would also be contrary to the duties that medical professionals may have as soldiers, for example, to prevent unnecessary pain or suffering or save a detainee's life.[14] Withdrawing or withholding basic medical care where a duty exists, and where the case does not fall within one of the permissible exceptions, thus cannot be justified by the duties that doctors owe as soldiers, as the duties would be aligned (as per the analysis for stage one). It is notable

[11] Such treatment could then be classified as stage six conduct. See Chapter Five, Section 4.2.
[12] Milton C. Weinstein, 'Should Physicians be Gatekeepers of Medical Resources?' (2001) 27 *Journal of Medical Ethics* 268; Kenneth V. Iserson, 'The Limits of Health Care Resources' (1992) 10 *The American Journal of Emergency Medicine* 588.
[13] See: *Wilmington General Hospital* v *Manlove* (1961) 174 A.2d 135.
[14] Article 35(2) of the 1977 Additional Protocol I: 'It is prohibited to employ weapons, projectiles and material and methods of warfare of a nature to cause superfluous injury or unnecessary suffering.' Article 20(2) of the Additional Protocol II: 'It is forbidden to employ weapons, projectiles, and material and methods of combat of a nature to cause superfluous injury or unnecessary suffering.'

that while withholding or withdrawing medical care would most likely trigger civil and disciplinary accountability, in certain circumstances and especially where this leads to an exacerbation of the injuries or the patient's death, it may also trigger criminal accountability.[15]

2.1.3. Forced-Feeding Detainees

The practice of force-feeding is not a recognised EIT, however, the evidence in Chapter One suggests that it may have been used as such. Generally, force-feeding is against the law, as it may amount to assault or battery.[16] It is also an act in violation of medical professional duties.[17] The Declaration of Malta, while not legally binding, sets out current medical ethical standards for medical professionals. The Declaration of Malta is clear that 'Physicians should respect individuals' autonomy… Forced feeding contrary to an informed and voluntary refusal is unjustified.' It adds that: 'Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment.'

However, in some circumstances, force-feeding may be both legally and ethically permissible: for example, where used to prevent a detainee's starvation and death, the medical professionals engaged in the practice on detainees[18] (as a quasi-emergency procedure) would not be in breach of their duties. This argument follows the reasoning in the ruling of the International Criminal Tribunal for the former Yugoslavia (ICTY) that medical professionals may resort to force-feeding where medically necessary to protect 'the health and welfare of the accused and avoid loss of life to the extent that such services

[15] Chapter Seven, Section 5.1.
[16] See Model Penal Code, §211.1.
[17] World Medical Association (WMA) Declaration of Malta on Hunger Strikes. See also: Chapter Four, Section 2.1; WMA, 'Declaration of Malta. A Background Paper on the Ethical Management of Hunger Strikes' (2006) 52 *World Medical Journal* 36.
[18] Shimon M. Glick, 'Unlimited Human Autonomy - A Cultural Bias?' (1997) 336 *New England Journal of Medicine* 954; Ryan Goodman and Mindy J. Roseman (eds.), *Interrogations, Forced Feedings, and the Role of Health Professionals: New Perspectives on International Human Rights, Humanitarian Law, and Ethics* (Harvard University Press: Cambridge MA, 2009) 75-102.

are not contrary to compelling internationally accepted standards of medical ethics or binding rules of international law.'[19]

The argument that force-feeding may be legally and ethically permissible, although in extremely limited cases, has gained some support in academic literature. For example, Gross claims that in the military, the requirement of patient autonomy that would ordinarily allow them to refuse certain treatment or even nutrition may be set aside by other considerations.[20] He does not suggest that this results in blanket permission to 'violate a fundamental human right in the name of military necessity.'[21] However, he claims that certain rights, such as the right to autonomy and informed consent to treatment, are not fundamental rights and so a lower threshold is to be applied to overriding them.[22] While this thesis concedes the legality of force-feeding for preserving the life and health of the detainees in emergencies, in order to be considered lawful it would still have to be conducted humanely.[23] Force-feeding may also be acceptable in line with the duties of medical professionals acting as soldiers, as their main consideration would be to ensure that detainees do not die in detention (especially where such death is preventable).[24] Hence, if force-feeding constitutes an emergency procedure and is conducted humanely, military and medical duties may be aligned. In any other case, however, these duties would be aligned to prevent military doctors from engaging in force-feeding.

Considering the character of American detention centres as closed institutions and the high health risk to the detainees, in certain situations, force-feeding may constitute an emergency procedure (to

[19] *Prosecutor* v *Šešelj* (2006) ICTY, Urgent Order to the Dutch Authorities Regarding Health and Welfare of the Accused, 15.1.
[20] Michael L. Gross, 'Force-Feeding, Autonomy, and the Public Interest' (2013) 369 *New England Journal of Medicine* 103. See also: Sandra L. Visser, 'The soldier and autonomy' in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 251.
[21] ibid.
[22] ibid.
[23] ibid.
[24] See US Department of Defence, 'Instruction 2310.08E, Medical Program support for detainee operations' (6 June 2006) 4.7.1.: 'In the case of a hunger strike, attempted suicide, or other attempted serious self- harm, medical treatment or intervention may be directed without the consent of the detainee to prevent death or serious harm. Such action must be based on a medical determination that immediate treatment or intervention is necessary to prevent death or serious harm, and, also, must be approved by the commanding officer of the detention facility or other designated senior officer responsible for detainee operations.' Also, Instruction, 4.7.3.: 'Detention facility procedures for dealing with cases in which involuntary treatment may be necessary to prevent death or serious harm shall be developed with consideration of procedures established by Title 28, Code of Federal Regulations, Part 549 (Reference (g)).'

save the life or health of these detainees who have no other access to medical care). However, in at least some cases, it is clear that the procedure has been used in a way that would not meet the test of having been conducted humanely. On the available evidence, it is not clear how representative this case is, but for Abu Wa'el Dhiad,[25] it is clear that the techniques used in force-feeding were very invasive, causing significant pain and suffering to the detainee. Furthermore, the reports discussed in Chapter One suggest that medical professionals have, on occasion, used the practice of force-feeding to punish detainees.[26] As such, medical professionals could not be justified in resorting to its practice.[27] Even though Gross considers that force-feeding may be lawful where used to preserve life, he likewise concedes that such force-feeding would still need to be conducted humanely and without the use of violence (to preserve the human dignity of the individual).[28]

Generally then, in the case of force-feeding, medical and military duties would have been aligned, requiring the medical professionals not engage with the practice. Nonetheless, in certain scenarios, in emergencies to preserve the life or health of the patient, military medical professionals, in their dual-capacity, may conduct force-feeding. In doing so they would then be following their military and medical duties. However, this would not extend to cases where the detainee does not face such an emergency and can give informed consent but refuses. It is noteworthy that, in the case of detainees in American detention centres, medical professionals were ordered to force-feed where a detainee's body weight dropped below 85 per cent of their ideal weight (for reasons not caused by protest, not religious fasting). It is questionable whether such a scenario would be enough to be classified as an emergency and to disregard the requirement of informed consent. In such a case, the medical professional carrying out force-feeding would be acting in breach of his medial duties. Nonetheless,

[25] Carol Rosenberg 'US Attorney Defends Guantánamo Hunger Striker's Forced-Feedings' *Miami Herald* (6 October 2014).
[26] ibid.
[27] Indeed, even the Instruction indicates that: 'Involuntary treatment or intervention under subparagraph 4.7.1. in a detention facility must be preceded by a thorough medical and mental health evaluation of the detainee and counselling concerning the risks of refusing consent. Such treatment or intervention shall be carried out in a medically appropriate manner, under standards similar to those applied to personnel of the U.S. Armed Forces.' Instruction (n 24) 4.7.2.
[28] ibid. However, it may be also considered that the very fact of denying the right to autonomy, independently whether this is done humanely, is a violation of human dignity and hence should not be allowed. See: George J. Annas, 'Military Medical Ethics - Physician First, Last, Always' (2008) 359 *New England Journal of Medicine* 1087.

in such non-emergencies, force-feeding, if conducted humanely, may accord with military duties to prevent unnecessary pain and suffering. This would create a dual loyalty conflict.

While force-feeding in itself may comply with medical and military duties, in emergencies, the techniques deployed may cause medical professionals to be in breach of their duties towards detainees. Conversely, if force-feeding is conducted inhumanely, military and medical duties would be aligned to prevent such practice.[29] It is noteworthy that force-feeding, where it is not an emergency procedure and where conducted inhumanely, may amount to criminal conduct and as such, would be subject to the considerations discussed in Chapter Five.

2.2. Monitoring EITs without Reporting

Monitoring EITs has legal and ethical implications where EITs constitute abuse that medical professionals are under a duty to report. The law, as it applies to the US Army, does not impose a general duty to report abuse.[30] Nonetheless, such a duty is enshrined in several military regulations. The duty concerns broadly defined acts, not only acts that amount to torture. As such whether EITs meet the legal definition of torture is irrelevant. The scope of the duty differs between different pieces of legislation. For example, under the US Navy Regulations, the Naval Service personnel is under a duty to report 'all offences under the Uniform Code of Military Justice which come under their observation' but not their own criminal conduct.[31] Similarly, the US Air Force Instruction imposes a broader duty to report any 'fraud, waste, abuse, or gross mismanagement; a violation of the law, policy, procedures, instructions, or regulations; an injustice; and any abuse of authority, inappropriate conduct or misconduct.'[32] All members of the US Department of Defence are under a qualified duty to report any crimes that constitute a violation of the Uniform Code of Military Justice. Furthermore, all US service members have an affirmative duty to report criminal acts.[33] This includes any detention

[29] If all other elements of the crimes are proven.
[30] See: US Department of the Army, 'Army Regulation 600-20. Army Command Policy', 4-23.
[31] US Department of the Navy, 'Change to US Navy Regulations in Light of US v Serianne' (2010).
[32] US Department of the Air Force, 'Instruction 1.1.' (2012) (as amended in 2014).
[33] US Department of Defence, 'Directive 2311.01E. Medical Program Support for Detainee Operations' (2006) (as amended in 2014 and 2017), 3(o).

operations. US Department of Defence personnel are under a duty to report 'possible, suspected, or alleged violations of the law of war, for which there is credible information, that occur in the context of detention operations.' As such, all EITs that constitute acts subject to the duty are to be reported. Medical professionals' duty to report abuse suffered by their patients is affirmed in law and medical professional norms.[34]

The Instruction puts a reporting system in place.[35] It guides ordinary medical professionals on the chain of command in reporting[36] and advises medical professionals to seek 'procedures for reporting instances of suspected noncompliance with standards applicable to detainee operations.'[37] However, as the reporting system is very limited and is not transparent, it may not be enough to reflect the otherwise present legal and medical professional norms. Medical professionals, even if acting in accordance with their military duties, would have been under a duty to report a broad range of acts that fall within the purview of 'abuse', as defined by corresponding laws, including torture and other criminal conduct. What this means is that, once again, medical and military duties would have been aligned, thus requiring medical professionals to report the abuse. A failure to do so would be a breach of the duties owed both as doctors and as soldiers.

2.3. Misusing Detainees' Medical Data for EITs

This section explores the issue of confidentiality and reporting abuse. The duty to record medical data is discussed in Chapter Five, Section 4.1, which examines the issue of medical professionals falsifying detainees' medical data and thus concealing evidence of the use of EITs. Once medical data is recorded, another question that emerges is who owns the medical data and how it affects medical professionals' duties towards the detainees as patients. The duty to respect privacy with regard to

[34] AMA Opinion 2.067 (1999), Chapter 9.7.5; WMA Declaration of Tokyo on Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (October 1975); Helen McColl, Kamaldeep Bhui and Edgar Jones, 'The Role of Doctors in Investigation, Prevention and Treatment of Torture' (2012) 105 *Journal of the Royal Society of Medicine* 464.
[35] See Instruction (n 24) 4.5.
[36] ibid E2.1.10.
[37] ibid.

medical data relates to all stages of the taxonomy. However, it is particularly relevant to stage four, misusing detainee's medical data for EITs, where medical professionals disclose the detainees' private and confidential medical data to the interrogators who then use the information to tailor the EITs.

Medical professionals handling medical data are under a duty of confidentiality that prevents them from sharing it with third parties without the detainee's consent or outside the scope of the extremely limited exceptions to the general rule. Some of the most common exceptions to the rule would be where a breach of confidentiality is necessary to protect others from harm,[38] in order to notify state agencies about contagious diseases[39] or to protect patients themselves.[40] Handling medical data is regulated by state law and medical professional norms. In the United States, 21 states have regulations on the ownership of medical data and managing them (including confidentiality and disclosure), with the provisions differing from state to state.[41] In the majority of these states, ownership of medical records is with the medical care provider or medical professional. Twenty-seven states do not have any laws detailing the specific ownership or property rights of medical records. In the remaining states where there is no statute on the issue, medical record ownership has been decided by common law.[42] However, ownership of medical data does not mean that medical professionals or medical care providers who own the data can disclose it as they wish. There are limitations on what the owners of such data can do. Furthermore, apart from relevant state law,[43] patients benefit from several additional rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Rule.[44]

[38] James F. Childress, Ruth R. Faden, Ruth D. Gaare, *et al.*, 'Public health ethics: mapping the terrain' (2002) 30 *Journal of Law, Medicine and Ethics* 170.
[39] Nancy E. Kass, 'Public Health Ethics: From Foundations and Frameworks to Justice and Global Public Health' (2004) 32 *Journal of Law, Medicine and Ethics* 232; Ronald Bayer, 'Public Health Policy and the AIDS Epidemic. An End to HIV Exceptionalism?' (1991) 324 *New England Journal of Medicine* 1500.
[40] Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Springer: Dordrecht, 2008)16.
[41] Health Information and the Law, 'Who Owns Medical Records: 50 States Comparison' http://www.healthinfolaw.org/comparative-analysis/who-owns-medical-records-50-state-comparison.
[42] *McGarry* v *J.A. Mercier Co.* (1935) 272 Mich. 501, 262 N.W. 296; *Holtkamp Trucking Co.* v *David J. Fletcher, M.D.* (2010) 402 Ill. App. 3d 1109, 932 N.E.2d 34.
[43] 45 CFR §160.203.
[44] 45 CFR Part 160.

The Privacy Rule establishes minimum standards for the protection of medical data, identifying the rights of individuals to access or change such data, and the right to obtain a record on when and how their data was shared with others. Persons subject to these provisions, are not to use or disclose individually identifiable health information unless they are expressly permitted to do so by the Privacy Rule.[45] Individuals in closed institutions, including inmates, also benefit from these protections. While the Privacy Rule provides inmates with some protection, there may be scenarios where institutions may be allowed to distribute and make use of inmates' medical information without their authorisation.[46] In accordance with current US law, such medical information may be used and disclosed without a patient's written authorisation in limited circumstances, for example, for treatment and care,[47] judicial and administrative proceedings,[48] law enforcement purposes,[49] to avert a threat to health or safety,[50] and for specialised government functions.[51] These exceptions are strictly regulated to prevent abuse (necessary to foster the trust that is crucial for the doctor-patient relationship).[52] Furthermore, the AMA Code of Medical Ethics imposes an ethical obligation on medical professionals to manage medical records accordingly;[53] medical records of current and past patients.[54] This duty suggests that privacy rights in medical data continue to be protected even when the fiduciary relationship comes to an end.

[45] 45 CFR §164.502(a).
[46] US Office of the Assistant Secretary for Planning and Evaluation, 'Standards for Privacy of Individually Identifiable Health Information' (2000) 82622.
[47] 45 CFR §164.506(a).
[48] 45 CFR §164.512(e).
[49] 45 CFR §164.512(f).
[50] 45 CFR §164.512(j).
[51] 45 CFR §164.512(k)(5)(i): 'A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for: (A) The provision of health care to such individuals;
(B) The health and safety of such individual or other inmates;
(C) The health and safety of the officers or employees of or others at the correctional institution;
(D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;
(E) Law enforcement on the premises of the correctional institution; or
(F) The administration and maintenance of the safety, security, and good order of the correctional institution.'
[52] Joy L. Pritts, 'The Importance and Value of Protecting the Privacy of Health Information: The Roles of the HIPAA Privacy Rule and the Common Rule in Health Research' (2008); Melissa M. Goldstein, 'Health Information Privacy and Health Information Technology in the US Correctional Setting' (2014) 104 *American Public Health Association* 803.
[53] AMA Code of Medical Ethics Opinion 3.3.1. Also: AMA Principles of Medical Ethics IV.
[54] ibid.

Even though the general duty of confidentiality is upheld in relation to prisoners, there are some exceptions. The National Commission on Correctional Health Care (the NCCHC) notes that the management of inmate medical records should mirror the management of medical records in civilian settings; such a move would serve to foster trust between medical professionals and prisoners.[55] Similarly, the American Public Health Association prescribes that 'prisoner-patients should be provided with the same privacy of health care information as patients in the community.'[56] However, the NCCHC also states that 'local, state, or federal laws may allow certain exceptions to the obligations of health care professionals to maintain confidentiality; health services staff should inform inmates at the beginning of the health care encounter when these circumstances apply.'[57] Indeed, Fred Cohen, professor of law, notes that a few federal courts have recognised inmates' right to privacy in medical records. However, the right is not absolute, and 'the state[58] has a legitimate interest in accessing such records and reporting relevant findings to prison executives.'[59] However, such exceptions should not mean enabling disclosure for the purposes of EITs.

The law relating to military settings is similar to the law applicable in civilian settings. Access to military medical records is determined by HIPAA and controlled by the US Department of Defence, Health and Human Services and Veterans Affairs.[60] While HIPAA ensures the protection of patients' medical data, it contains some exceptions specific to the use and access of military medical data. For example, HIPAA permits the disclosure of military medical data under the so-called Military Command Exception.[61] The Military Command Exception is an exception for 'authorised activities', including an assessment of fitness for duty or a special assignment. It is at this point that a conflict of

[55] NCCHC, *Standards for Health Services in Jails* (National Commission on Correctional Health Care: Chicago, IL, 2008) 15-16.
[56] APHA Task Force on Correctional Health Care, *Standards for Health Services in Correctional Institutions* (American Public Health Association: Washington, DC, 2003) 7.
[57] ibid 116.
[58] Here 'state' means a federal unit.
[59] Fred Cohen, 'No Medical Records Privacy for an Inmate in Sexual Predator Commitment Proceeding' (2010) 22 *Correctional Law Reporter* 35; *Seaton* v *Mayberg* (2010) 610 F.3d 530; *Doe* v *Delie* (2011) 257 F.3d 309, 311; *Powell* v *Schriver* (1999) 175 F.3d 107, 112.
[60] Roger Collier, 'Irreconcilable Choices in Military Medicine' (2010) 182 *Canadian Medical Association Journal* E821-E822.
[61] See: 45 CFR 164.512(k)(1). Furthermore, even if disclosed to the command authorities, and hence not subject to HIPAA, the medical data still benefits from the protection of the Privacy Act of 1974.

dual loyalties may occur, with doctors bound by the medical duty towards their patients (to act in their best interest), and soldiers bound by their duty towards the state under the Military Command Exception. However, this exception applies to the medical data of Armed Forces personnel only. As such, it is unlikely that the Military Command Exception would apply to the medical data of detainees in American detention centres. The question would be whether medical data could be disclosed if there were a threat to national security. There are certain challenges in using the national security argument in the case study of this thesis to justify the disclosure of detainees' medical data. First, the argument of national safety is not well-grounded in facts as detainees have been kept in detention for a prolonged time without contact with the outside world. Furthermore, disclosure of the medical data would not avert the potential threat to national security but would only provide the interrogators with data that may help administer EITs which abuse detainee's physical or psychological vulnerabilities. Lastly, based on the evidence discussed in Chapter One, it is not clear whether the argument is being relied upon in specific cases, but the national security argument has been used as blanket permission to assess medical data. This does not accord with the law discussed above.

It is clear from the above discussion that, independent from the setting, the medical data of the detainees (patients) is protected, although to a different degree depending on the settings and subject to limited exceptions. Both medical and military duties are generally aligned to require medical professionals to respect detainees' confidentiality, with disclosure being lawful only in specified, limited exceptions. It is within these exceptions where the dual loyalty conflict may occur.[62] In such a case, the medical professional may be required to disclose the data despite it being against the best interest of the patient (detainee), and hence, in breach of their fiduciary duties.

The analysis above demonstrates that a dual loyalties conflict is not inevitable and should not be treated as such. While the medical profession is usually perceived as a profession that is highly regulated by law and medical professional norms, the military profession is also regulated, imposing

[62] 45 CFR §164.512(j).

numerous duties upon soldiers.[63] Indeed, many of the corresponding duties in both professions, in the case study of this thesis, are highly aligned.[64] Based on the above analysis, it is clear to see dual loyalties conflicts in a limited number of scenarios where medical professionals provide basic medical care without consent (stage one), conduct force-feeding (stage eight) and misuse detainees' medical data (stage four). Conflict occurs in an extremely limited number of cases. The next question is, where a dual loyalties conflict occurs, how should it be resolved, notwithstanding the solution proposed by the US Administration.

3. Resolving the Conflict of Dual Loyalties

The Instruction relies on blanket claims that there is a conflict between medical and military duties, but once we drill down into the detail of concrete examples of medical involvement – which the taxonomy allows us to do – the relevant duties in each of these specific contexts tend to align quite closely, except for a limited number of scenarios. It is nonetheless crucial to consider how such conflicts could and should be resolved when they do. To do so, this thesis argues that the response must shift our attention away from recognising that, as a matter of empirical fact, military doctors are likely to have institutional loyalties, and focus on the legal issues, which turn on the existence of a fiduciary relationship. As a matter of law, the existence of other duties cannot be understood as always and unavoidably forcing medical professionals to abandon their fiduciary duties. Dual loyalties cannot be considered to be the overriding factor but as potentially offering a degree of (practical) limitation to how far the medical professionals are able to discharge their fiduciary duties towards their patients.[65] To hold otherwise would undermine the premise of the fiduciary relationship. Indeed, when considering the potential conflict between the duties, it is crucial to recognise the unique nature of the fiduciary duties they owe to their patients. As a matter of law, fiduciary duties occupy a

[63] Samuel P. Huntington, *The Soldier and the State: The Theory and Politics of Civil-Military Relations* (Belknap Press of Harvard University Press: Cambridge MA, 1957).
[64] William Madden and Brian S. Carter, 'Physician-Soldier: A Moral Position' in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003) 269.
[65] Marc A. Rodwin, 'Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System' (1995) 21 *American Journal of Law and Medicine* 251, 256.

different place in the hierarchy of duties, meaning that they should not be simply abandoned where they clash with other non-fiduciary duties.

In any case, where there may be a conflict of dual loyalties, this thesis argues that fiduciary loyalties should prevail. Indeed, there is a growing body of experts who argue that, because of the unique nature of the fiduciary relationship, a conflict of dual loyalties should be resolved in favour of their fiduciary duties. Among others, Marcia Angell, medical professional, notes that: 'the doctor's role [is] to serve each individual patient unstintingly.'[66] Similarly, Norman G. Levinsky, professor of medicine, suggests that: 'the doctor's master must be the patient'[67] even if there are other pressures, for example, to serve society. Conversely, the US Administration's assertion[68] that any other duties, such as - in the case study of this thesis - duties towards the state, should always and inevitably trump fiduciary duties, is not supported. For example, Marc A. Rodwin, professor of law, who was willing to accept that fiduciary duties may be affected by other duties, was clear that any conflict of loyalties does not mean that the fiduciary duty would be abandoned altogether. He proposes that only where the conflict is too great to be resolved will it be accepted that the medical professional could not perform both roles.[69] His argument should not be read as requiring that medical professionals abandon their fiduciary duties towards their patients in favour of other duties that they may have. Indeed, among others, Rubenstein and George J. Annas, professors of medicine, convincingly argue that such an approach is reserved for extreme exceptions rather than establishing a default rule.[70]

When dual loyalties conflicts may be present, Solomon Benatar and Ross Upshur, professors of medicine, claim that they may be resolved if valid analogies can be established between the conflicts

[66] Marcia Angell, 'Medicine: The Endangered Patient-Cantered Ethic' (1987) 17 *The Hastings Centre Report* 12.
[67] Norman G. Levinsky, 'The Doctor's Master' (1984) 311 *New England Journal of Medicine* 1573, 1575.
[68] See Instruction (n 24).
[69] Rodwin (n 65) 256.
[70] Leonard S. Rubenstein and George J. Annas, 'Medical Ethics at Guantanamo Bay Detention Centre and in the US Military: A Time for Reform' (2009) 374 *The Lancet* 353–5; George J. Annas, Sandra S. Crosby and Leonard H. Glantz, 'Guantanamo Bay: A Medical Ethics-free Zone?' (2013) 369 *New England Journal of Medicine* 101–103; Seumas Miller and Michael J. Selgelid, 'Ethics and the dual-use dilemma in the life sciences' in Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Springer: Dordrecht, 2008)195; Alex J. Bellamy, 'No Pain, No Gain? Torture and Ethics in the War on Terror' (2006) 82 International Affairs 121; Leonard S. Rubenstein, 'Medicine and War' (2004) 34 *Hastings Centre Report* 6.

in military and civilian settings,[71] be it an epidemic or other public health crisis.[72] They argue that this may mean that, in certain situations, for example in cases of communicable disease control, the best interest of a patient may be subordinated to the collective good, both in civilian and military settings. However, this approach fails, in the context of the case study for this thesis, for three reasons. First, there is a fundamental difference between subordinating a patient's best interest to the collective good and resorting to unlawful conduct. Furthermore, how is the balance between the patient's best interest and collective good assessed? Based on what considerations? Second, recalling Gross' two-stage consideration discussed in previous chapters, the relevant question is not whether the act can be justified but whether medical involvement in the act can be justified.[73] Again, it is important to remember that medical professionals have a different status and play a different role in society. Third, their analysis fails to adequately address the fact that the military medical professionals may belong to two professions: medical and military, while civilian medical professionals belong to just one, even in the event of a public health crisis. Therefore, the situation of military medical professionals is different and must be analysed as such. Nonetheless, Benatar and Upshur's analysis is still relevant as it is aimed at normalising medical engagement in the military, arguing that 'the ethical responsibilities of health care professionals to their patients are the same in the military context as in civilian life.'[74]

The vast majority of academic commentators, in adherence to international standards, recognise that medical professionals are bound by law and medical professional norms even when embedded in the military and during armed conflicts.[75] However, considering the challenges that medical professionals continue to face, that often require them to abandon their medical duties and medical independence,

[71] Solomon R. Benatar and Ross E.G. Upshur, 'Dual Loyalties of Physicians in the Military and Civilian Life' (2008) 12 *Public Health and the Military* 2161.
[72] ibid 2163.
[73] Michael L. Gross, 'Bioethics and Armed Conflicts. Mapping the Moral Dilemmas of Medicine and War' (2004) 6 *Hasting Centre Report* 29, 34.
[74] Benatar and Upshur (n 71).
[75] Leonard S. Rubenstein, 'First, Do No Harm: Health Professionals and Guantanamo Bay' (2007) 37 *Seton Hall Law Review* 733; Gretchen Borchelt, 'Break Them Down' (Physicians for Human Rights, 2005); Rubenstein and Annas, (n 70) 374 The Lancet 353; Vincent Iacopino, Scott A. Allen and Allen S. Keller, 'Bad Science Used to Support Torture and Human Experimentation' (2011) 331 *New Series* 34.

the question is what would need to change to ensure that medical professionals can preserve their loyalty towards their patients? This is where the analysis by Leslie London, professor of public health, Rubenstein and others becomes relevant. London, Rubenstein and others assert the need for an 'approach grounded in human rights, which ensures that the duties that respect and protect human dignity remain at the core of health professional practice.'[76] This argument may be read to incorporate the need to respect human rights standards by medical professionals acting in the double capacity. However, while London, Rubenstein and others correctly recognise the human rights obligations of medical professionals as the deciding factor, they fail to consider that soldiers also have remarkably similar obligations: above all, not to engage in criminal or unlawful conduct. This omission has led to a failure to consider such cases where there would be no conflict of dual loyalties. London, Rubenstein and others proposed adherence to human rights guarantees where the actors are clear about their obligations. However, as it is based on the erroneous assumption that both duties conflict, the argument only partially addresses the issue. Nonetheless, the approach proposed by London, Rubenstein and others provides for a good foundation to address the issue of dual loyalties. Indeed, an approach grounded in human rights law should be applied to interpret the duties of medical professionals towards their patients and third parties. An approach seeking to resolve dual loyalties conflicts that fully reflects relevant law and ethics must take into consideration the challenges faced by medical professionals.

The challenges faced by medical professionals in the military could be addressed with a focus on the fiduciary relationship and by prioritising medical duties flowing from the fiduciary relationship. A fiduciary relationship has a unique status in law as it is underpinned by fiduciary duties which are to be fulfilled to the highest standard.[77] The unique nature of the doctor-patient relationship has been

[76] London, Rubenstein *et al.* (n 1) 381. See also: Eric Stover and Elena O. Nightingale (eds.), The Breaking of Bodies and Minds (W.H. Freeman and Co.: New York, 1985) 32; British Medical Association, Medicine Betrayed (Zed Books: London, 1992).

[77] Marc A. Rodwin, 'Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System' (1995) 21 *American Journal of Law and Medicine* 251, 256; Deborah A. DeMott, 'Beyond Metaphor: An Analysis of Fiduciary Obligation' (1988) *Duke Law Journal* 879; Eileen A. Scallen, 'Promises Broken vs. Promises Betrayed: Metaphor, Analogy, and the New Fiduciary Principle' (1993) *University of Illinois Law Review* 897.

recognised by scholars[78] and in US jurisprudence. Indeed, as Justice Koch suggests, 'fiduciary duties are the highest standard of a duty imposed by law.'[79] Similarly, Justice Cardozo, a former judge at the US Supreme Court, found that fiduciary duties differ from any other duties.[80] According to Justice Cardozo:

> many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the marketplace. Not honesty alone, but the *punctilio* of an honour the most sensitive, is then the standard of behaviour... Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd.[81]

In *Kozan* v *Comstock*, the court emphasised the unique nature of the fiduciary relationship finding that:

> The duty of due care is imposed by law and is something over and above any contractual duty. Certainly, a physician could not avoid liability for negligent conduct by having contracted not to be liable for negligence. The duty is owed in all cases, and a breach of this duty constitutes a tort. On principle then, we consider a malpractice action as tortious in nature whether the duty grows out of a contractual relationship or has no origin in the contract.[82]

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[78] Cecil Helman, 'Introduction: The Healing Bond' in Cecil Helman (ed.) *Doctors and patients. An Anthology* (Radcliffe Medical Press: Abingdon, 2003) 1; Thomas L. Hafemeister and Sarah Payne Bryan, 'Beware Those Bearing Gifts: Physicians' Fiduciary Duty to Avoid Pharmaceutical Marketing' (2009) 57 *University of Kansas Law Review* 491, 520; Paul D. Finn, 'The Fiduciary Principle' in Timothy G. Youdan (ed.), *Equity, Fiduciaries and Trusts* (Carswell: Toronto, 1989) 33; Edwin C. Hui, 'The Patient-Surgeon Relationship. Part II: Medical Fidelity as Morality and Law' (2005) 17 *Asian Journal of Oral and Maxillofacial Surgery* 210; Edwin C. Hui, 'The Patient-Surgeon Relationship. Part II: Medical Fidelity as Morality and Law' (2005) 17 *Asian Journal of Oral and Maxillofacial Surgery* 210.

[79] *Overstreet* v *TRW Commercial Steering Div.* (2008) 256 S.W.3d 626, 641. See also: *First Tennessee Bank National Association* v *C.T. Resorts Co.* (1995) WL 511884, 5; Nicolas P. Terry, 'Physicians and Patients Who "Friend" and "Tweet" Constructing a Legal Framework for Social Networking in a Highly Regulated Domain' (2010) 43 *Indiana Law Review* 285, 304.

[80] *Meinhard* v *Salmon* (1928) 164 N.E. 545, 546.

[81] ibid.

[82] *Kozan* v *Comstock* (1959) 270 F.2d 839, 844-45.

Elsewhere, as in *Petrillo* v *Syntex Labs., Inc.,* the court further recognised the 'sanctity' of the doctor-patient fiduciary relationship stating that:

> The existence of this fiduciary relationship indicates that there is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to pay. There is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the "good faith" required of a fiduciary. The patient should, we believe, be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship.[83]

The above examples show how courts have approached the issue of the doctor-patient relationship distinguishing it from contractual relationships and emphasising the higher standards applicable to medical professionals. This jurisprudence highlights the unique nature of the fiduciary relationship in tort law, recalling that it can be imposed even in situations where it is expressly denied.[84] The unique nature of the doctor-patient relationship is also commonly accepted. One study conducted in the United States revealed that those interviewed 'believe the patient-physician relationship is second in importance only to the family relationship in their society and that it far exceeds in importance spiritual relationships, financial relationships and co-worker relationships.'[85] This shows that expecting medical professionals to prioritise their fiduciary relationship is not novel or unreasonable. The US Administration does not make any explicit reference to the unique nature of the fiduciary relationship. However, the absence of such explicit reference should not be read as an objection to such an interpretation of the fiduciary relationship. Indeed, the fact that the US Administration

[83] *Petrillo* v *Syntex Labs.* (1986) 148 Ill. App.3d, 594.
[84] This is further closely related to the issue discussed in Chapter Three, that the fiduciary relationship can be imposed by a court in certain cases where the fiduciary relationship has not been established by way of the medical professional accepting fiduciary duties.
[85] Mike Magee, 'Relationship-Based Health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan. A Comparative Study of Patient and Physician Perceptions Worldwide' (2003) 7 *The Journal of Biolaw and Business*.

attempts to distance BSCs from the fiduciary relationship in the Instruction[86] may implicitly suggest some recognition of the unique nature of the relationship and the duties that it imposes.

Considering the unique nature of the fiduciary relationship between medical professional and patient, it is unreasonable to suggest that any clash between fiduciary duties and other duties should simply be resolved in favour of the other duties. On the contrary, it is argued that when considering the different duties or loyalties medical professionals may have, it is crucial to analyse the duties engaged as not existing on an equal footing but, rather, within a hierarchy of duties where fiduciary duties would override the non-fiduciary duties. This follows the analysis in *Petrillo* v *Syntex Labs., Inc,* where the court acknowledged that the sanctity of the doctor-patient relationship is of paramount importance for the analysis of the conflicting duties and should take precedence over the other duties.[87] A growing number of judgments have followed to confirm *Petrillo* in identifying the important status of the doctor-patient relationship and recognising that the protection of the relationship is an important public policy.[88]

However, the case study of this thesis poses unique challenges in terms of the fiduciary relationship both because of the nature of the military itself, which is strongly hierarchical[89] and because of the national interests that may be at stake. These two elements constitute challenges that medical professionals would not encounter elsewhere, or not to the same degree. Indeed, in this case study, medical professionals may face 'a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest.'[90] This is the case, particularly where concurring duties are considered to be fundamentally different and

[86] The US Administration, in its Instruction, prescribes that BSCs and medical professionals assisting BSCs are not in a fiduciary relationship with the detainees. See: Instruction (n 24).
[87] *Petrillo* v *Syntex Labs.* (1986) 148 Ill. App.3d, 608.
[88] *Sorensen* v *Barbuto* (2008) UT 8, 177 P.3d614, 619-20; *State ex rel. Dean* v *Cunningham* (2006) 182 S.W.3d 561, 566; *Walk* v *Ring* (2002) 44 P.3d 990, 999; *Moore* v *Regents of Univ. of Cal*. (1990) 793 P.2d479, 483; *Hammonds* v *Aetna Casualty & Surety Co.* (1965) 243 F. Supp. 793.
[89] Robert J. Lifton, 'Doctors and Torture' (2004) 351 New England Journal of Medicine 415-416; Mark J. Osiel, *Making Sense of Mass Atrocity* (Cambridge University Press: New York, 2009) 95; Mark J. Osiel, *Obeying Orders: Atrocity, Military Discipline and Law of War* (Transaction Publishers: New Brunswick, 1999) 1.
[90] Bernard Lo and Marilyn J. Field (eds.), *Conflict of Interest in Medical Research, Education, and Practice* (The National Academies Press: Washington DC, 2009).

potentially in conflict with fiduciary duties towards a patient. This thesis recognises and accepts that there are arguments that support the view that those duties owed to the state should take priority. For example, here, the relevant argument would state that military duties (even those that resort to EITs) might be justified with the paramount importance of national security.[91] Indeed, such an argument, and especially in the case of the ticking-bomb emergency scenario, is usually used to challenge, on practical grounds, the legal and ethical standards on the prohibition of torture or other human rights abuses.[92] However, the validity of the ticking-bomb emergency scenario has been challenged. For example, David Luban, professor of law and philosophy, notes that the ticking-bomb debates are based on exaggerated hypotheticals such that one would find it difficult not to justify the use of torture. He further adds that: 'ticking-bomb stories depict torture as an emergency exception, but use intuitions based on the exceptional case to justify institutionalised practices and procedures of torture.'[93] The ticking bomb scenario is unlikely to apply in the case study of this thesis. Detainees are kept in American detention centres for several years and hence their intelligence may be out of date and ineffectual for national security imperatives. Indeed, this is evidenced in the SSCI report discussed in Chapter One. The SSCI report indicates that none of the evidence obtained from EITs has been of any value.[94] Furthermore, while the argument may justify some involvement by the military or CIA agents, as Gross convincingly argues, this does not mean that medical professionals' involvement should be justified.[95] Considering the above, there are legitimate reasons why the presumption should generally work in favour of fiduciary duties.

[91] Oren Gross, 'Are Torture Warrants Warranted? Pragmatic Absolutism and Official Disobedience' (2004) *88 Minnesota Law Review* 1481. See also: Alan M. Dershowitz, *Why Terrorism Works: Understanding the Threat, Responding to the Challenge* (Yale University Press: New Haven, 2002) 149. It is noteworthy that Dershowitz claims that the use of torture is justified in exceptional cases only.
[92] David Luban, 'Liberalism, Torture, and the Ticking Bomb' (2005) 91 *Virginia Law Review* 1425; Oren Gross (n 91) 735.
[93] ibid 1427.
[94] Chapter One, Section 3.4.
[95] Gross (n 73).

4. Conclusion

The analysis in this chapter shows that the majority of cases concerning medical professionals involved EITs in American detention centres that do not amount to criminal conduct, would not pose a dual loyalties conflict that would justify them in abandoning their legal and medical professional norms. Hence, the argument that military duties would always and inevitably trump medical duties does not stand scrutiny. Considering that the duties are often aligned, a conflict of dual loyalties cannot be used to justify the act. Indeed, medical professionals involved in EITs are not only in breach of their medical duties but also their military duties. Nonetheless, it cannot be neglected that medical professionals face institutional loyalties that will affect their conduct.

Only in an extremely limited number of scenarios will the military and medical duties of medical professionals conflict, requiring those medical professionals to choose to follow one or the other. Indeed, it is only with regard to a relatively narrow set of circumstances where such a conflict is likely, involving the provision of medical care without the detainees' consent, force-feeding that does not constitute an emergency treatment but is conducted humanely, or misuse of detainees' medical data for EITs. Even in such cases, this thesis argues that fiduciary duties should be prioritised. This position recognises the unique nature of the fiduciary relationship between medical professionals and their patients. Conversely, the argument that the fiduciary relationship can be abandoned whenever it clashes with non-fiduciary duties undermines the premise of the fiduciary relationship to the point that the concept becomes meaningless. Having this in mind, the next chapter considers ways that medical professionals could be held to account for their involvement in EITs, taking into consideration the existence of the fiduciary relationship.

CHAPTER SEVEN: Avenues for Disciplinary, Civil and Criminal Action against Medical Professionals in American Detention Centres

1. Introduction

The previous chapters challenged the arguments that the US Administration relies upon to protect medical professionals from accountability for their involvement in EITs, namely that 1) medical professionals and the detainees are not in a fiduciary relationship, and 2) the duties towards the state would override some duties towards detainees (as patients). To date, no medical professional involved in EITs in American detention centres has been formally held accountable for their conduct,[1] whether by way of disciplinary, civil or criminal proceedings. This chapter moves to assess how this might be remedied. It asserts that whilst arguments about the fiduciary relationship were not central to the failure of earlier legal actions, relying on the existence of a fiduciary relationship between medical professionals and detainees is key to many of the legal avenues.

Before discussing the specific available routes of legal recourse, the chapter sets out the salient differences between the different kinds of action (Section 2). It analyses four disciplinary complaints made against medical professionals and discusses the reasons why they failed (Section 3). It argues that state medical boards have erred in law by failing to find against doctors in these cases and, as such, they cannot fulfil their role effectively. Second, it explores the civil routes towards accountability, focusing specifically on claims under the Alien Tort Statute 1789,[2] claims for medical malpractice, and especially, claims for breach of the fiduciary relationship. This section analyses the only relevant civil suit, *Salim* v *Mitchell,* which settled out of court (Section 4). Third, this chapter explores options for criminal prosecutions in domestic courts in the US (Section 5). Whilst little attention was given to the existence, or not, of a fiduciary relationship in the limited existing case law, this thesis will argue that the existence of a fiduciary relationship between medical professionals

[1] David J. Nicholl, Trefor Jenkins, Steven H. Miles *et al*., 'Biko to Guantánamo: 30 Years of Medical Involvement in Torture' (2007) 370 *Lancet* 823.
[2] 28 USC § 1350 (Alien Tort Statute).

and detainees will, in fact, be key to the success of action in many instances. This is an under-explored aspect that requires attention.

2. Navigating Avenues for Legal Recourse

In order to determine which means of holding doctors accountable for their actions is most appropriate, it is important to consider a range of aspects beyond the level of wrongdoing, including, for example, the mental state of the medical professionals, the chances of success and also the kind of redress sought by the victim. Indeed, while similar acts may trigger a range of different legal actions,[3] the main differences relate to 1) the *mens rea*, 2) the standard of proof (which, along with the *means rea*, has the ultimate bearing on the prospect of a successful legal action), and 3) the legal consequences of the action.

For example, the *mens rea* requirement differs significantly in criminal, civil and disciplinary actions.[4] The Model Penal Code (MPC), which codified and unified criminal law across states of the US,[5] although not yet adopted by all, recognises four criminal states of mind: acting purposely (intentionally), knowingly, recklessly, and negligently.[6] The *mens rea* requirement for intentional tort

[3] Michael C. Barnes and Stacey L. Sklaver, 'Active Verification and Vigilance: A Method to Avoid Civil and Criminal Liability when Prescribing Controlled Substances' (2013) 15 *DePaul Journal of Health Care Law* 93, 96. However, for medical disciplinary proceedings the actionable acts are much broader, for example, 'failure to maintain for a patient a medical record which meets the minimum standards stated in the rules and regulations promulgated by the commission' and 'Performance of unnecessary diagnostic tests or medical or surgical services.' (Section 34-24-360 of the Alabama Medical Practice Act).

[4] Although, certain crimes require specific intent, namely intent in relation to the act and also the result (*US* v *Blair* (1995), 54 F.3d 639; *Thornton* v *State* (2007) 397 Md. 704)).

[5] Sanford H. Kadish, 'Fifty Years of Criminal Law: An Opinionated Review' (1999) 87 *California Law Review* 943, 953.

[6] See Section 2.02 of the MPC: '(a) Purposely. A person acts purposely with respect to a material element of an offense when:
(i) if the element involves the nature of his conduct or a result thereof, it is his conscious object to engage in conduct of that nature or to cause such a result; and
(ii) if the element involves the attendant circumstances, he is aware of the existence of such circumstances or he believes or hopes that they exist.
(b) Knowingly. A person acts knowingly with respect to a material element of an offense when:
(i) if the element involves the nature of his conduct or the attendant circumstances, he is aware that his conduct is of that nature or that such circumstances exist; and
(ii) if the element involves a result of his conduct, he is aware that it is practically certain that his conduct will cause such a result.
(c) Recklessly. A person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a law-abiding person would observe in the actor's situation.

liability requires intent,[7] while the tort claim of negligence requires a lesser state of mind and can be evidenced by a person who acts with 'no due care.'[8] For strict liability[9] and disciplinary proceedings, *mens rea* is not necessary. By contrast, the relevant standard of proof for criminal liability is 'beyond reasonable doubt';[10] however, the threshold is lower for tortious claims, where evidence need only demonstrate that a course of events is 'more probable than not.'[11] In medical disciplinary proceedings, state medical boards must decide whether a violation of a state's Medical Practice Act[12] has been proven, in accordance with the lower standard of 'on the basis of substantial evidence.'[13] Similarly, the types of redress differ among legal actions. Criminal proceedings may result in imprisonment or fine, civil suits in damages, and disciplinary proceedings in revocation or suspension of the certificate to practise medicine. These are all relevant considerations for choosing the appropriate legal action.

Furthermore, while criminal or unlawful conduct may result in several different avenues for legal recourse, the current practice shows that there is a relationship between them. For example, disciplinary proceedings often depend on criminal proceedings. According to Kelly K. Dineen and James M. DuBois, professors of medical ethics, 'criminal investigations and charges are almost always reported to [state medical boards] and criminal prosecutions are the most likely disciplinary trigger to lead to serious [state medical boards] action against a physician.'[14] Furthermore, they note that 'conviction of a felony often results in automatic revocation of a license to practice medicine.'[15]

(d) Negligently. A person acts negligently with respect to a material element of an offense when he should be aware of a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that the actor's failure to perceive it, considering the nature and purpose of his conduct and the circumstances known to him, involves a gross deviation from the standard of care that a reasonable person would observe in the actor's situation.'

[7] In *Global-Tech Appliances, Inc.* v *SEB S.A.* (2010) 2068, 2071–72.

[8] Fleming James, 'Scope of Duty in Negligence Cases' (1953) 47 *Northwestern University Law Review* 778.

[9] *Rylands* v *Fletcher* (1868) 3 LRE & I App. 330 (HL); Restatement (Second) of Torts §520.

[10] In *re Winship*, the court found that 'the accused against conviction except upon proof beyond a reasonable doubt of every fact necessary to constitute the crime with which he is charged.' *Re Winship* (1970) 397 U.S. 358.

[11] *Colorado* v *New Mexico* (1984) 467 U.S. 310. The standard of 'clear and convincing' means that the evidence must be highly and substantially more likely to be true than untrue.

[12] Federation of State Medical Boards, 'US Medical Regulatory Trends and Actions' (2018).

[13] The wording is taken from Section 34-24-360 of the Alabama Medical Practice Act. This will differ from state to state.

[14] Kelly K. Dineen and James M. DuBois, 'Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?' (2016) 42 *American Journal of Law and Medicine* 7. See also: Christopher J. Kim, 'The Trial of Conrad Murray: Prosecuting Physicians for Negligent Over-Prescription' (2014) 51 *American Criminal Law Review* 517, 532.

[15] Dineen and DuBois (n 14) 7. See also: Revised Statutes of Missouri §334.103(1) (2008): 'A license issued under this chapter by the Missouri State Board of Registration for the Healing Arts shall be automatically revoked at such time as

Therefore, criminal prosecutions increase the chances of a state medical board initiating disciplinary proceedings. However, the two should not depend on each other, as they rely on completely different standards of proof and serve different purposes. As such, the lack of criminal prosecution should not deter disciplinary proceedings.[16]

The ultimate choice of legal recourse may be challenging, and especially where the conduct in question can and should trigger criminal accountability. As Jeffrey A. Barker, a practising lawyer, correctly notes, 'criminal liability is the strongest formal condemnation that society can inflict.'[17] However, holding medical professionals accountable for their involvement in EITs should not mean punishment in the form of criminal sanctions only. As shown in the previous chapter, not all EITs, would inevitably amount to criminal conduct, they may constitute unlawful acts that should trigger a lesser form of accountability, civil or disciplinary for example.[18] Indeed, Dineen and DuBois stress that 'law enforcement faces complex determinations of (1) the point at which a medical purpose becomes illegitimate; (2) the boundaries of usual practice; and (3) the extent at which crossing those boundaries warrants criminal liability.'[19] They note that 'the line between practice and criminality is a foundational question because criminal liability threatens individuals' essential liberties far beyond

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the final trial proceedings are concluded whereby a licensee has been adjudicated and found guilty, or has entered a plea of guilty or *nolo contendere*, in a felony criminal prosecution under the laws of the state of Missouri, the laws of any other state, or the laws of the United States of America for any offense reasonably related to the qualifications, functions or duties of their profession, or for any felony offense involving fraud, dishonesty or an act of violence, or for any felony offense involving moral turpitude, whether or not sentence is imposed, or, upon the final and unconditional revocation of the license to practice their profession in another state or territory upon grounds for which revocation is authorised in this state following a review of the record of the proceedings and upon a formal motion of the state board of registration for the healing arts. The license of any such licensee shall be automatically reinstated if the conviction or the revocation is ultimately set aside upon final appeal in any court of competent jurisdiction.'

[16] The American Medical Association (AMA) Code of Medical Ethics states: 'Ethical values and legal principles are usually closely related, but ethical responsibilities usually exceed legal duties. Conduct that is legally permissible may be ethically unacceptable. Conversely, the fact that a physician who has been charged with allegedly illegal conduct has been acquitted or exonerated in criminal or civil proceedings does not necessarily mean that the physician acted ethically. In some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust, they should work to change in law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.'

[17] Jeffrey A. Barker, 'Professional-Client Sex: Is Criminal Liability an Appropriate Means of Enforcing Professional Responsibility?' (1993) 40 *UCLA Law Review* 1289. See also: Andrew Ashworth, *Principles of Criminal Law* (Oxford University Press: New York, 2006); Herbert L.A. Hart, *Punishment and Responsibility* (Oxford University Press: New York, 2008) 4-5; Joshua Dressler, *Understanding Criminal Law* (Carolina Academic Press: Durham NC, 2018) 4.

[18] Barker (n 17) 1283.

[19] Dineen and DuBois (n 14).

those threatened by civil liability or professional discipline.'[20] For example, as the court in *United States* v *Feingold* found, a case concerning a medical professional distributing or dispensing a controlled substance, 'knowing how doctors generally ought to act is essential for a jury to determine whether a practitioner has acted not as a doctor, or even as a *bad* doctor, but as a "pusher" whose conduct is without legitimate medical justification.'[21] The court in *United States* v *MacKay* clarifies that, for example, the criminal standard required for criminal negligence, goes far beyond a simple breach of the standard of care that a medical professional is bound to adhere to:

> the case presented the jury with the difficult task of first deciding if MacKay's prescriptions left the legal terrain of medically helpful pain management. Then, if the jurors were persuaded there was such a departure, they faced the perhaps even more difficult task of deciding whether such behaviour constituted a kind of medical malpractice, which, although negligent, is not criminal, or whether the doctor had knowingly and intentionally left the field of medicine altogether to become a criminal drug dealer.[22]

Applying this analysis to the case study of this thesis poses the following questions: 1) has the medical professional departed from their ordinary medical duties (as providing medical care, treating injuries, managing pain etc.); and 2) are the acts so culpable and harmful as to amount to criminal conduct? Considering the ten-stage taxonomy set out in Chapter One, the answer to the first question will, in many cases, be affirmative. The second question depends on the stage of the taxonomy, and indeed, Chapters Five and Six laid down an important distinction between criminal and non-criminal conduct.

Lastly, Edward Monico, medical professional, *et al,* who commented on the blurring lines between civil and criminal legal avenues, suggested that 'in the end, what will tip the criminal vs. civil balance

[20] ibid.
[21] *US* v *Feingold* (2006) 454 F.3d 1001, 1007. The court found that: 'Only after assessing the standards to which medical professionals generally hold themselves is it possible to evaluate whether a practitioner's conduct has deviated so far from the standard of care.'
[22] *US* v *MacKay* (2014) 20 F. Supp. 3d 1287, 1297.

might be whether justice would be better served if a medical act or omission requires the defendant to pay the victim for the loss or whether the defendant should pay society for the loss.'[23] This consideration relates in part to the redress sought by the victim but is also expressive of the potential of the law. However, as identified above, because of the different elements and thresholds, the redress sought is not the only consideration.

The above shows that while there are several kinds of legal action that might be relevant in cases where medical professionals' are involved in criminal or other unlawful acts, there are important differences between them which will influence which is most appropriate in the circumstances of a specific case. Furthermore, the existence of the fiduciary relationship is also relevant, albeit in different ways, to each of them. With this in mind, the analysis below discusses some of the disciplinary, civil and criminal avenues for legal recourse that are available and may be successful in the case study of this thesis. With regard to each of these various types of legal actions, the chapter argues that the existence of a fiduciary relationship plays an important role. The fiduciary relationship shapes the existing avenues of legal recourse available against medical professionals but also opens up new and otherwise unavailable avenues for imposing accountability. Indeed, the fiduciary relationship equips patients with one of the most powerful legal protections, which partly address the shortcoming of other legal actions:[24] the action for breach of fiduciary duty. As Mehlman argues, '[i]n effect, fiduciary law offsets a weaker interpersonal position in the fiduciary relationship with a stronger legal position in the event of a breach by the fiduciary.'[25] In the context of a medical professional's involvement in EITs, the fiduciary relationship provides for an additional – and,

[23] Edward Monico *et. al*., 'The Criminal Prosecution of Medical Negligence' (2006) 5 *Internet Journal of Law, Healthcare and Ethics* 1, 22.
[24] Kim Johnston, 'Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives' (1998) 35 *San Diego Law Review* 95, 958; Maxwell J. Mehlman, 'Dishonest Medical Mistakes' (2006) 59 *Vanderbilt Law Review* 1137; D. Gordon Smith, 'The Critical Resource Theory of Fiduciary Duty' (2002) 55 *Vanderbilt Law Review* 1399, 1410.
[25] Mehlman (n 24) 1137.

indeed, given the procedural and evidential thresholds, often the only – legal recourse to hold them to account.[26]

However, certain challenges require further attention. For example, one challenge relates to the issue of knowledge of the EITs and the intention of the medical professionals who were involved in them. While the requisite knowledge of EITs could be constructed, the intention behind each medical professional's involvement would need to be established. Here, medical professionals could have been influenced by a broad range of factors, including institutional loyalties. This wide variety of factors cannot be neglected. As such, engaging with the question results in a significant evidentiary burden. Any attempt to translate the legal analysis into legal action would require robust evidence and this remains lacking both because existing reports are significantly redacted, and because it is difficult to prove *mens rea* (which would also turn partly on documentary evidence).

3. Disciplinary Proceedings

All medical professionals are under a duty to adhere to medical professional norms as prescribed by the relevant state medical boards.[27] A failure to do so may result in disciplinary sanctions. Medical professionals are also bound by the norms established by domestic medical associations, and a failure to abide by them may result in their membership being rescinded.[28]

3.1. The Role of State Medical Boards

State medical boards are responsible for, among others, issuing practising licences for medical professionals, thereby certifying them as qualified and fit for practice,[29] investigating and suspending them when they are in breach of legal and professional norms, and by doing so, protecting the public.[30]

[26] Barker (n 17) 1275; Mark A. Hall, Mary Anne Bobinski and David Orentlicher, *Medical Liability and Treatment Relationships* (Aspen Publishers: New York, 2008).
[27] Federation of State Medical Boards, 'US Medical Regulatory Trends and Actions' (2018).
[28] For example, American Medical Association, American Psychological Association, American Psychiatric Association.
[29] Drew Carlson and James N. Thompson, 'The Role of State Medical Boards' (2005) 7 *Virtual Mentor* 311.
[30] See for example: *Bang D. Nguyen* v *The Department of Health, Medical Quality Assurance Commission* (2001) 144 Wn.2d 516, 29 P.3d 689.

As Timothy S. Jost, professor of law, notes 'protecting the public from incompetent professionals has long been recognised as the primary justification for professional licensure.'[31] The regulations vary between states, however, some common examples of prohibited conduct include inadequate medical data-keeping, failure to recognise or treat symptoms, physical abuse of patients, a conviction of a felony, and dishonesty.[32] Despite the majority of these examples also amounting to criminal offences, disciplinary proceedings may also be triggered for seemingly less serious breaches, such as the 'performance of unnecessary diagnostic tests or medical or surgical services.'[33]

Professional medical codes do not have the force of law.[34] However, as Angela Campbell and Kathleen Cranley Glass, lawyers, note, they constitute 'soft law'[35] that may exhort medical professionals' behaviour but are not legally enforceable *per se*.[36] Nonetheless, they are 'binding on all occasions unless [they are] in conflict with equal or stronger duties.'[37] As Tom L. Beauchamp and James F. Childress, professor of philosophy and professor of ethics respectively, suggest:

> because they are always morally relevant, they constitute strong moral reasons for performing the acts in question, although they may not always prevail over other *prima facie* duties. One's actual duty is thus determined by the balance of the respective weights of the competing *prima facie* duties in the situation. One might say that *prima facie* duties count even when they do not win.[38]

[31] Timothy S. Jost, 'Oversight of the Competence of Healthcare Professionals. In Regulation of the Healthcare Professions' in Timothy S. Jost (ed.), *Regulation of the Healthcare Profession* (Health Administration Press: Chicago, 1997) 20.
[32] ibid. See, for example: Ohio Administrative Section 4731.22.
[33] Section 34-24-360 of the Alabama Medical Practice Act.
[34] Alexander E. Limentani, 'The Role of Ethical Principles in Health Care and the Implications for Ethical Codes' (1999) 25 *Journal of Medical Ethics* 394, 395.
[35] Angela Campbell and Kathleen Cranley Glass, 'The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research' (2001) 46 *McGill Law Journal* 473.
[36] ibid. See also: Daniel Jutras, 'Clinical Practice Guidelines as Legal Norms' (1993) 148 *Canadian Medical Association Journal* 905.
[37] ibid 395.
[38] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (Oxford University Press: New York, 2001) 52.

Many medical professional norms are reflective of existing legal duties. For example, the norm not to perform unnecessary diagnostic tests or medical or surgical services reflects legal provisions criminalising insurance fraud and also battery, where an unnecessary surgical procedure is performed.[39] This was further discussed in Chapter Six, which compares the fiduciary and non-fiduciary duties that medical professionals hold, identifying their manifestations in law. Furthermore, medical professional codes, as soft law, '[have] been important in assisting courts with questions of professional responsibility', especially in the absence of legal norms on an issue. In this way, medical professional codes may evolve into law and become binding as such.[40] For this to happen, the medical professional codes would have to be tested in court and scrutinised against the existing legal standards,[41] with courts retaining the ultimate discretion to decide against accepting the medical professional norms.[42] For example, in *Canterbury* v *Spence*, the court decided against following the professional practice standard where it found that a 'professional custom hardly furnishes the legal criterion for measuring the physician's responsibility to reasonably inform his patient of the options and the hazards as to treatment.'[43] The court added that 'prevailing medical practice… has evidentiary value in determinations as to what the specific criteria measuring challenged professional conduct are and whether they have been met, but does not itself define the standard.'[44] Legal and professional norms are closely interrelated. Where a legal standard requires medical professionals to act in good faith or reasonably, that will be reflected in professional practice standards that turn, in part, on professional codes of conduct.[45]

[39] Isaac D. Buck, 'Overtreatment and Informed Consent: A Fraud-Based Solution to Unwanted and Unnecessary Care' (2016) 43 *Florida University Law Review* 902.
[40] Campbell and Cranley Glass (n 35) 488.
[41] ibid 480.
[42] *Canterbury* v *Spence* (1972) 464 F.2d 772.
[43] ibid 785. See also: *Montgomery* v *Lanarkshire Health Board* [2015] UKSC11, 95 where the UK Supreme Court found that: 'There is no question in this case of Dr McLellan's being entitled to withhold information about the risk because its disclosure would be harmful to her patient's health. Although her evidence indicates that it was her policy to withhold information about the risk of shoulder dystocia from her patients because they would otherwise request caesarean sections, the "therapeutic exception" is not intended to enable doctors to prevent their patients from taking an informed decision. Rather, it is the doctor's responsibility to explain to her patient why she considers that one of the available treatment options is medically preferable to the others, having taken care to ensure that her patient is aware of the considerations for and against each of them.'
[44] ibid 785.
[45] ibid.

Where medical professionals violate medical professional norms, state medical boards can impose a wide range of sanctions, from mere reprimand to temporary or permanent revocation of licence.[46] These powers are crucial as other legal recourse may not be available or are inadequate, for example, actions for malpractice 'are not always reliable measures of a physician's competence or a violation of the law.'[47] However, even where the option of disciplinary sanction is available, Leonard L. Riskin, professor of law, notes that professional bodies shy away from taking actions against medical professionals who act in breach of their professional duties.[48] The system is so inadequate that, as Paul R. Van Grunsven, a judge, argues, criminal prosecution for misconduct has been rendered necessary.[49] DuBois goes even further to suggest that, based on his analysis of 280 cases, 'the field of medicine has self-regulated in a manner that protects self-interests above patient interests.'[50] This raises significant practical problems.

While Riskin's argument concerns disciplinary proceedings in general, it is clearly born out in the case study of this thesis. Over the years, as more evidence was brought to light, several actors have filed complaints with state medical boards against some of the medical professionals involved in the practice of EITs.[51] Some of the examples are discussed below. This section argues that state medical boards erred in law in failing to find against doctors in these cases and as such, they cannot fulfil their role effectively. The section then moves to consider why these actions have not proven successful.

[46] Federation of State Medical Boards, 'US Medical Regulatory Trends and Actions' (2018) 69.
[47] ibid 8.
[48] Leonard L. Riskin, 'Sexual Relations Between Psychotherapists and Their Patients: Toward Research or Restraint' (1979) 67 *California Law Review* 1000, 1002, 1006. See also: Atul Gawande, 'When Good Doctors Go Bad', New Yorker (7 August 2000) 60; Darren Grant and Kelly C. Alfred, 'Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards' (2007) 32 *Journal of Health Politics, Policy and Law* 867.
[49] Paul R. Van Grunsven, 'Medical Malpractice or Criminal Mistake? An Analysis of Past and Current Criminal Prosecutions for Clinical Mistakes and Fatal Errors' (1997) 2 *DePaul Journal of Health Care Law* 1; John Alexander Harris and Elena Byhoff, 'Variations by State in Physician Disciplinary Actions by U.S. Medical Licensure Boards' (2017) 26 *BMJ Quality and Safety* 200; Timothy S. Jost, 'Oversight of the Quality of Medical Care: Regulation, Management or the Market' (1995) 37 *Arizona Law Review* 863–64.
[50] James M. DuBois *et al.*, 'Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States from 2008–2016' (2019) 19 *American Journal of Bioethics* 16, 25.
[51] To be able to practise medicine in the United States, medical professionals must obtain medical licensure from the state where they wish to practise. See: AMA, Obtaining a Medical License.

3.1.1. State Medical Boards Responses to Medical Involvement in EITs

Many of these complaints, filed by medical professionals and detainees with state medical boards,[52] are centred on the actions of four doctors and their staff, namely: Dr John S. Edmondson, Commander of the US Navy Hospital at Guantánamo Bay; Dr James E. Mitchell, psychologist and former member of the United States Air Force, and the author of EITs; John Francis Leso, psychologist, major in the United States Armed Services, and the first Behavioural Science Consultation Teams' psychologist at Guantánamo Bay; and Lieutenant Colonel Diane Michelle Zierhoffer, Army psychologist. Complaints have been made regarding almost all stages of the taxonomy discussed in Chapter One. For example, the complaints against Dr James E. Mitchell alleged that he designed EITs used by the CIA (stage three).[53] Medical staff under the supervision of Dr Edmondson have been accused of sharing detainees' medical data with interrogators (stage four).[54] Captain John Francis Leso was accused of failing to maintain medical records on patients' injuries and conditions (stage five).[55] The complaint against Captain John Francis Leso, who is known to have participated in the use of EITs on Mohammed al Qahtani,[56] alleged breaches of medical professional norms including performing unduly authorised medical services (stages six, but also eight and/or ten).[57] The complaint against Lieutenant Colonel Diane Michelle Zierhoffer[58] claims that she instructed the investigators to use EITs on a detainee, Mohammed Jawad (stage seven), despite being aware that he suffered from severe psychological symptoms.[59] Medical staff, under the supervision of Dr Edmondson, were also accused

[52] The exact procedure differs between state medical boards. For example, in accordance with the Medical Board of California procedure, a complaint can be sent by anyone, including by a member of the general public and 'the complaint and all accompanying documentation are reviewed by a consumer services analyst and a medical consultant, if applicable, to determine if possible violations of the Medical Practice Act exist that warrant further action.' Medical Board of California, *Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons* (Medical Board of California, 2013) 23.
[53] Complaint to the Texas State Board of Examiners of Psychologists by Jim Cox against James E. Mitchell (17 June 2010) 27.
[54] Complaints to the Medical Board of California by Sarim *et al*. against John Edmondson (11 July 2005).
[55] Complaint to the New York Office of Professional Discipline by Dr. Trudy Bond against John Leso (5 April 2007).
[56] Centre for Constitutional Rights, 'When Healers Harm: Hold Health Professionals Accountable for Torture' https://ccrjustice.org/when-healers-harm-hold-health-professionals-accountable-torture.
[57] Complaint to the New York Office of Professional Discipline by Dr. Trudy Bond against John Leso (5 April 2007).
[58] Complaint to the Texas State Board of Examiners of Psychologists by Jim Cox against James E. Mitchell (17 June 2010) 27.
[59] Complaint to the Alabama Board of Examiners by Dr. Trudy Bond against Dr. Diane Zierhoffer (21 November 2008).

of force-feeding detainees (stage eight).[60] The medical staff of Dr Edmondson[61] and Captain John Francis Leso[62] allegedly refused to provide medical treatment until detainees agreed to cooperate (stage nine). The complaints against Dr Edmondson,[63] Captain John Francis Leso[64] and Dr James E. Mitchell[65] accused each of them of having participated in abuse and ill-treatment (stage ten). Dr James E. Mitchell was further accused of conducting experiments on human subjects without consent (stage ten).[66]

The complaints have raised diverse arguments covering involvement in criminal acts,[67] breaches of medical professional norms[68] and breach of the fiduciary duties[69] between medical professionals and the detainees (as patients).[70] None of the complaints brought against medical professionals involved in EITs administered in American detention centres have resulted in formal investigations, let alone disciplinary proceedings, notwithstanding the severity of the allegations of professional misconduct and criminal conduct. The reasons for not proceeding with the investigations and disciplinary proceedings were equally diverse. These are discussed below.

i. The Lack of Jurisdiction

First, some of the state medical boards argued that they lacked subject matter jurisdiction.[71] They claim that they were not able to investigate a medical professional practising at a federal facility unless the federal government did so first. This is despite the fact that the Superior Court of California

[60] Letter from Jim H. Mcnatt, MD, Medical Director, Georgia Composite State Board of Medical Examiners, to Dr. David Nicholl (26 June 2007).
[61] Complaints to the Medical Board of California by Sarim *et al*. against John Edmondson (11 July 2005).
[62] Complaint to the New York Office of Professional Discipline by Dr. Trudy Bond against John Leso (5 April 2007).
[63] Complaints to the Medical Board of California by Sarim *et al*. against John Edmondson (11 July 2005).
[64] Complaint to the New York Office of Professional Discipline by Dr. Trudy Bond against John Leso (5 April 2007).
[65] Complaint to the Texas State Board of Examiners of Psychologists by Jim Cox against James E. Mitchell (17 June 2010) 27.
[66] ibid.
[67] Complaint to the Louisiana State Board of Examiners of Psychologists by Dr. Trudy Bond against Larry James (29 February 2008).
[68] It is noteworthy that while the complaints were filed with state medical boards, they often rely on the medical norms established by medical associations.
[69] Complaint to the Ohio State Board of Psychology by Michael Reese, Trudy Bond, Colin Bossen, and Josephine Setzler against Larry James (7 July 2010).
[70] ibid.
[71] *Sarim* v *Medical Board of California* (2006) 4–5.

confirmed that the state medical boards have jurisdiction to hear the complaints.[72] Second, some state medical boards have argued that they lack territorial jurisdiction. It is supposing that this argument has been overlooked, given that it is clearly flawed. Ultimately, state medical boards are designated to determine medical professionals' fitness to practice medicine. Where a medical professional is accused of involvement in criminal conduct in the discharge of his or her medical duties (even if this takes place abroad), his or her fitness to practice is called into question. Presumably, it is not the intention that medical professionals should practise medicine (or use their medical expertise) outside of the US in breach of law and medical professional norms through involvement in EITs) and yet be considered fit to practise on their return to the US. As Amrit K. Bal and B. Sonny Bal, medical professionals, correctly observe, 'physicians are held to a higher standard of moral and personal conduct than the general population… [A]ctions that reflect poor judgment, flawed character, and sub-standard decision-making may trigger state medical board sanctions.'[73]

Ultimately, medical professional norms exist to protect patients, and the state medical boards are the guardians of these norms.[74] If medical professionals fail to do so, they forsake the very reason for which they were established. Indeed, Donald J. Meyer and Marilyn Price, medical professionals, suggest that 'the board's client is the public' and not medical professionals.[75] Such inquiries and investigations of the medical professionals accused of involvement in EITs should be considered a public interest and the duty of state medical boards.[76] Medical state bodies cannot be seen as fulfilling their duties in a case where they certify the fitness to practice of medical professionals who are involved in criminal or unlawful conduct, whether domestically or abroad. Holding medical

[72] ibid.
[73] Amrit K. Bal and B. Sonny Bal, 'Medicolegal Sidebar: State Medical Boards and Physician Disciplinary Actions' (2014) 472 *Clinical Orthopaedics and Related Research* 28.
[74] Institute of Medicine, Committee on Clinical Practice Guidelines, 'Guidelines for Clinical Practice: Front Development to Use' (National Academy Press: Washington, DC, 1992) 1-22.
[75] Donald J. Meyer and Marilyn Price, 'Peer Review Committees and State Licensing Boards: Responding to Allegations of Physician Misconduct' (2012) 40 *Journal of the American Academy of Child and Adolescent Psychiatry* 193, 199. See also: Gregg M. Bloche, *The Hippocratic Myth. Why Doctors Are Under Pressure to Ration Care, Practice Politics, and Compromise their Promise to Heal* (Palgrave Macmillan: New York, 2011)167-9.
[76] *Re Revocation of License of Kindschi* (1958) 52 Wn.2d 8, 319 P.2d 824; *Bang D. Nguyen* v *The Department of Health, Medical Quality Assurance Commission* (2001) 144 WN.2d 516, 29 P.3d 689.

professionals to account for such involvement in EITs should be the priority of state medical boards, and especially, where the patient is a vulnerable individual.[77]

Furthermore, from the medical professionals' point of view, obligations towards patients (detainees) do not depend upon the latter's location. According to the Federation of State Medical Boards,

> Through licensing, state medical boards ensure that all practising physicians have appropriate education and training and that they abide by recognised standards of professional conduct while serving their patients… After physicians are licensed, they must renew their license periodically, usually every one or two years, to continue their active status. During this license renewal process, physicians must demonstrate that they have maintained acceptable standards of ethics and medical practice and have not engaged in improper conduct.[78]

If they are involved in conduct such as EITs, medical professionals cannot possibly 'demonstrate that they have maintained acceptable standards of ethics' or refrained from engaging in improper conduct. Simply put, if state medical boards are concerned with doctors' fitness to practice, they cannot ignore behaviour simply because it occurs in another country.

Another question would be whether state medical boards should take account of a doctor having been struck off in another country. If so, this would further support the position that state medical boards should properly pay attention to doctors' acts outside of the US, especially where such acts reveal the medical professional as unfit to provide medical services to the public. There are very few reported cases on the issue, however, the case of Richard Kaul may provide some assistance. In 2001, Kaul was struck off in the UK after being found guilty of negligent manslaughter. He subsequently moved to New Jersey, US, and practised medicine there.[79] In 2003, the state medical board temporarily

[77] Barker (n 17) 1278.
[78] Federation of State Medical Boards, 'US Medical Regulatory Trends and Actions' (2018) 6.
[79] Brent Johnson, 'NJ Board Revokes License of Doctor for Performing Spinal Surgery Without Proper Training' *NJ* (12 February 2014).

suspended him for failing to disclose his conviction in the UK. His licence was subsequently revoked on the basis that he had operated without adequate training.[80] The Richard Kaul case makes it clear that misconduct abroad is relevant to a medical professional's fitness to practice. However, it is noteworthy that in that case, he was suspended for six months because he had not disclosed his conviction rather than because of his serious misconduct in the UK. Furthermore, while misconduct abroad is of relevance to a medical professional's fitness to practice medicine, a conviction may be necessary. Medical professionals in the case study have not faced any legal accountability for their involvement in the EITs abroad and as such, it is unlikely that their conduct abroad would have any bearing on their fitness to practice medicine in the US or result in disciplinary sanctions.

Similarly, it may be inferred from the US Department of Defence Instruction that the location did not affect the duties of medical professionals. As the Instruction makes clear, while the duties of medical professionals vary depending on the status of medical professionals (ordinary medical professionals and BSCs had different roles), their location would not have had such an effect on their duties. This in itself suggests that they do not believe the jurisdictional issue to be a bar.

State medical boards are neglecting their core task, protecting the public, in refusing to hear these cases. The question which must be asked is: who is the 'public' that they are supposed to protect? Or is that concept jurisdictionally restricted? Do they owe a duty to the US public only? State medical boards owe their duties to the public in the US. Ultimately, state medical boards, by licencing medical professionals, certify their fitness to practice and enable them to practise medicine in the US. One could argue that, as medical professionals may perform their duties abroad, this duty should extend to the public in other jurisdictions, especially if the boards know of activities that place into question a medical professional's fitness to practice medicine. Understandably, if US medical professionals provide medical services abroad, they would have to be certified to do so in accordance with the requirement in that country and so, subject to the laws and medical professional norms of that country.

[80] ibid.

However, in the case study of this thesis, there is no suggestion that medical professionals involved in EITs were qualified to practice medicine in the countries where they operated. Indeed, they practised within American detention centres where they were subject to US laws and medical professional norms.[81] While state medical boards have duties to the US public, they can discharge these duties by making sure that medical professionals who use their medical expertise for involvement in criminal or unlawful acts abroad are prohibited from practising medicine in the US.

ii. The Lack of Evidence

Some state medical boards have claimed that after a thorough investigation and review of various information and medical records, there was not sufficient evidence to support any further action for the alleged violations.[82] However, they have generally refused to publish details of what such a thorough investigation involved and the documents which were made available to them to inform their considerations.[83] A lack of evidence should not preclude an investigation. The information that is available in the public domain may not be enough to assist with proceedings. The evidence that may be missing concerns not only the abuse suffered by detainees, but also particulars of the involvement of medical professionals in that abuse. It is the role of the state medical boards to gather such information, including by interviewing the doctors concerned.

Conducting such investigations is particularly important because of the nature of American detention centres. As discussed in Chapter One, medical professionals often failed to make an adequate record of the use of EITs or the injuries the patient (detainee) endured. Hence, a lot of critical evidence is not recorded and, to acquire this evidence, the victims and other witnesses would have to be interviewed before any consideration or decision could be made. Furthermore, the very failure to

[81] See: The White House, Office of the Press Secretary, Statement by NSC Spokesperson Bernadette Meehan on the US Presentation to the Committee Against Torture, 12 November 2014.
[82] Letter from Jim H. Mcnatt, MD, Medical Director, Georgia Composite State Board of Medical Examiners, to Dr. David Nicholl (26 June 2007); Danny Robbins, 'Texas Board Won't Discipline CIA Psychologist' *Associated Press* (25 February 2011). See also Tex. Gov't. Code, § 2001.056; Tex. Admin. Code, §§ 469.5(h), 470.8(a)(2), (a)(4).
[83] Letter from Carolyn Knauss, Investigator, to Dr. Trudy Bond (16 September 2008).

record medical data is a breach of the duties that medical professionals owe (stage five).[84] Only through opening formal investigations,[85] would the state medical boards be able to obtain the evidence necessary to consider the complaints. It is difficult to accept that state medical boards are fulfilling their role of protecting the public where they fail to investigate such serious allegations of misconduct as the EITs.

iii. The Lack of Legal Standing

Some state medical boards found that the complainants did not have sufficient legal standing to progress the complaints. For example, the complaint against Dr Leso filed by Dr Steven Reisner was rejected on grounds of a lack of jurisdiction[86] and a lack of grounds for the complaint.[87] However, once Dr Resiner challenged the decision with the New York District Court, his petition was dismissed on the basis that he had no standing to bring the case.[88] Generally, such a complaint does not have to be brought forward by the victim. Indeed, the relevant law prescribes that '[t]he board for professional medical conduct, by the director of the office of professional medical conduct, may investigate on its own any suspected professional misconduct, and shall investigate each complaint received regardless of the source.'[89]

Similarly, other state medical boards allowed the complaint to be filed by an individual other than the patient, following their own rules and procedures.[90] For example, the Medical Board of California identifies that anyone may file a complaint, including members of the public and medical professionals.[91] Often, detainees cannot file such complaints themselves, because of a language

[84] See Chapter Five, Section 4.1.
[85] For example, according to the Medical Board of California, 'the complaint and all accompanying documentation are reviewed by a consumer services analyst and a medical consultant, if applicable, to determine if possible violations of the Medical Practice Act exist that warrant further action.' Medical Board of California, *Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons* (Medical Board of California, 2013) 23.
[86] Complaint to the New York Office of Professional Discipline by Steven Reisner against John Leso (7 July 2010) 1.
[87] Letter from Louis J. Catone to Kathy Roberts, Esq, Centre for Justice and Accountability (28 July 2010) 2.
[88] *Reisner* v *Catone* (2011) 929 N.Y.S.2d 403.
[89] New York Consolidated Laws, Public Health Law § 230.10.
[90] See for example: Alabama Board of Medical Examiners, 'Filing a Complaint' https://www.albme.org/Documents/cmpltinstrrel.pdf.
[91] Medical Board of California, *Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons* (Medical Board of California, 2013) 23.

barrier for example, and the complaints made by their representatives (or third parties with relevant authority from the victims, for example, the power of attorney) should have been accepted. However, as with the complaint of Dr Resiner, the issue was that he did not officially represent the victim. As such, he did not have a legal standing to bring forward the complaint. This means that if the victim or their representatives do not initiate the complaint, for example, where the victim for various reasons is unable to proceed,[92] perhaps through repercussion, others with relevant knowledge cannot resort to this avenue. Allowing applications from someone other than the person directly affected is in line with the state board's duty to protect the public, not just an individual patient.

3.1.2. The Limitations of the State Medical Boards

Among the multiple allegations described above, only in the complaint against Larry James was it clearly pleaded that the medical professionals involved in EITs were in breach of their fiduciary duties, and hence, should be investigated by the state medical board for such a breach.[93] There are benefits of pleading a breach of the fiduciary relationship expressly and in parallel to other allegations, rather than assuming it to be included. The weakness in pleading only involvement in torture or other criminal conduct is that if a complainant fails to prove the constituent elements of the crime and the medical professional's involvement therein, the case would fail. However, relying on the fiduciary relationship and the associated duties may offer a lower threshold for finding liability. Once the fiduciary relationship is established and if it is possible to show that the medical professionals involved were in breach of the duties flowing from it, independent of the act perpetrated or harm caused, medical professionals should face disciplinary consequences for the breach. In the case of fiduciary duties, it is the mere fact of the breach of duty that triggers legal and disciplinary consequences.[94] However, even in the James case, the Ohio State Board of Psychology decided that

[92] See for example: David Luban, 'Lawfare and Legal Ethics in Guantánamo' (2008) 60 *Stanford Law Review* 1981.
[93] Complaint to the Louisiana State Board of Examiners of Psychologists by Dr. Trudy Bond against Larry James (29 February 2008).
[94] See for example: Thomas L. Hafemeister and Richard M. Gulbrandsen, 'The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that Are Not Medically Indicated' (2009) 39 *Seton Hall Law Review* 335, 375.

they were unable to proceed with formal action. The procedures of state medical boards limit them in relation to the information they can disclose during the different stages of the disciplinary procedure[95] and, unfortunately, the reasons for their decision. Hence it is not possible to know the grounds upon which a claim for breach of fiduciary duty was rejected.

To add pressure to state medical boards to engage with the complaints, in one of the cases, the complainants sought a writ of mandamus, a court order, to urge a state medical board to proceed to formal action against a medical professional.[96] As an alternative, the application asked for an order to 'compel the [state medical board] to investigate meaningfully and in good faith and determine whether to proceed to formal action' and to 'provide clearly articulated reasons grounded in fact or law for any decision and to show that it investigated meaningfully and/or carried out a formal proceeding in good faith.'[97] The court dismissed the request,[98] finding that for the order to be granted, 1) the complainant must have a clear legal right to the relief, 2) the respondent must have a clear legal duty to provide the requested relief, and 3) the complainant must have no plain and adequate remedy available in the ordinary course of the law. The court found that while the state medical board may reprimand a doctor or suspend his or her licence, there is no law to require it to initiate disciplinary action or to provide an explanation for its failure to do so. The question is then: how state medical boards are meant to discharge their duties towards the public when actions against medical professionals require their discretion? Such an approach undermines the effectiveness of state medical boards to fulfil their primary duties.

Despite the long list of failed attempts, bringing disciplinary proceedings against medical professionals involved in the EITs in American detention centres remains the most feasible option to respond to a wide range of criminal and non-criminal conduct. The reluctance of state medical boards

[95] Section 230, State Board for Professional Medical Conduct; Proceedings. Available at: https://www.nysenate.gov/legislation/laws/PBH/230.
[96] *Dr. Trudy Bond et al.* v *State Board of Psychology* (2011) Writ of mandamus. Available at: http://hrp.law.harvard.edu/wp-content/uploads/2013/06/Decn-dismiss3.pdf.
[97] ibid.
[98] *Dr. Trudy Bond et al.* v *State Board of Psychology* (2013) 11CV-4711.

to engage with complaints against medical professionals is not an issue exclusive to the case study of this thesis and is representative of systemic failures of these bodies to fulfil their primary duties to protect the public. The failure of state medical boards investigating medical involvement in the EITs has attracted criticism from medical and human rights experts. For example, as Stephen N. Xenakis, an army medical professional, and Rubenstein correctly argue, the failures to investigate and discipline medical professionals involved in EITs are 'an unconscionable disservice to the thousands of ethical doctors and psychologists in the country's service.'[99] In this specific case, where medical professionals are facing accusations of severe criminal conduct, as in the more advanced stages of the taxonomy introduced in Chapter One, the state medical boards' inaction is ever more glaring, posing the question of whether they are fit for the purpose in their current form. It is clear that the voluntary nature of the investigatory function prevents the bodies from fulfilling their role as guardian to the public. Using their medical expertise for criminal or unlawful conduct, acting in breach of their fiduciary duties with patients, these are straightforward cases of acts revealing medical professionals as unfit for practice. The existence of the fiduciary relationship between medical professionals and detainees should open the door for the state medical boards to engage and investigate breaches of the fiduciary relationship. There is no political will among the medical board to hear these cases but if that changed, there is every possibility that doctors could be struck off, or have their licenses suspended, on the basis of existing principles and procedures.

3.2. The Role of Professional Associations

Apart from being bound by medical professional norms, as prescribed by state medical boards, medical professionals are to adhere to norms established by professional associations. Professional associations, for example, the American Medical Association, are clear that their members must not engage in criminal or otherwise unethical acts.[100] However, such associations are voluntary associations with the only sanctions being reprimands, fines, or expulsion. Currently, medical

[99] Leonard S. Rubenstein and Stephen N. Xenakis, 'Doctors Without Morals' *NY Times* (28 February 2010).
[100] See for example: 'Criminalisation of Medical Judgment, Resolution 223', Proceedings of AMA Interim Meeting 1993.

professional associations do not have the power to investigate individual complaints. Miles argues that such professional associations (especially domestic) can and should play a role in ensuring the accountability of medical professionals for their involvement in EITs as torture.[101] However, for them to be able to do so, he suggests that several changes must happen to how such medical associations operate and deal with the unlawful or unprofessional conduct of their members:[102] specifically, they 'should perform and publish audits to assess whether courts and licensing boards are holding torture doctors accountable.'[103] This is a reasonable proposal which would provide such associations with a role in ensuring that there is a degree of transparency in the process. Furthermore, as identified above, state medical boards can investigate violations of the norms established by medical associations. However, this has proven unsuccessful to date, for the reasons set out above, including state medical boards rejecting complaints claiming lack of jurisdiction, lack of evidence, and lack of legal standing.

4. Civil Proceedings

Under US law, there are a few civil actions that may be relevant to the liability of medical professionals, including actions for intentional torts, negligence and torts of strict liability. For the claim of intentional torts, one has to prove that the wrongdoer had the required mental state and intended the action that results in harm.[104] An action in negligence is available where there is a duty, breach of that duty (the tortfeasor fails to act as a reasonable person would have acted under the same or similar circumstances), causation and damage.[105] Where medical professionals are in a fiduciary relationship with the detainee, the medical professional could be held to account by way of a specialised type of negligence claim, medical malpractice. This action may be especially relevant where it is difficult to prove that medical professionals acted with the relevant *mens rea*, for example,

[101] Steven H. Miles, 'Medical Associations and Accountability for Physician Participation in Torture' (2015) 17 *AMA Journal of Ethics* 945.
[102] ibid.
[103] ibid.
[104] The relevant intentional torts are for example, battery, assault, and intentional infliction of emotional distress. See: John C.P. Goldberg and Benjamin C. Zipursky, *The Oxford Introductions to US Law: Torts* (Oxford University Press: Oxford, 2010) 131.
[105] ibid 83.

in committing an intentional tort. A strict liability claim may be possible too, in cases involving abnormally dangerous activities.[106] However, for medical professionals in American detention centres, the most promising avenues for breach of a fiduciary relationship and medical negligence. Furthermore, this section examines the only successful legal avenue to date: actions under the Alien Tort Statute 1789.[107]

It is noteworthy that the availability of civil avenues for legal recourse will depend not only on the location of the conduct in question but also the contractual relationship between medical professionals and the military. This question turns on whether the medical professional is an employee or contractor. §1346(b)(1) of the Federal Tort Claims Act 1946 (FTCA)[108] provides US district courts with exclusive jurisdiction over civil actions against the United States for the wrongful acts of US Government's employees while acting within the scope of their employment. The Medical Malpractice Immunity Act 1976 (the Gonzalez Act)[109] protects medical personnel in the Armed Forces from individual malpractice actions for their conduct, whether a negligent or wrongful act or omission, 'while acting within the scope of his duties or employment' and provides that the remedies under the FTCA are an exclusive avenue for compensation. Both apply only where the medical personnel are employed by the military. However, the Gonzalez Act direction in 10 USC §1089(e) states that:

> (e) For purposes of this section, the provisions of section 2680(h) of title 28 shall not apply to any cause of action arising out of a negligent or wrongful act or omission in the performance of medical, dental, or related health care functions (including clinical studies and investigations).

[106] ibid 263. One of the examples of EITs that may be abnormally dangerous may be waterboarding. For strict liability, no wrongful intent is needed.
[107] 28 USC § 1350 (Alien Tort Statute).
[108] 28 USC. §§ 1346 (b), 2671-2680.
[109] 10 USC § 1089.

The direction in 10 USC §1089(e) distinguishes between the conduct of medical professionals within the scope of their duties or employment and the performance of medical duties. This again refers back to the issue of whether the medical professional is in a fiduciary relationship with their patient (detainee). If the medical professionals were acting within the scope of their duties or employment and were not in a fiduciary relationship, an individual action against them would not be available. On the other hand, where medical professionals act within the scope of their employment but are involved in the negligent or wrongful act or omission when discharging their military duties, while under their fiduciary relationship, an action in tort is available as against that medical professional. As the US Supreme Court found in *Levin* v *United States et al*, 'the Gonzalez Act direction in 10 USC §1089(e) abrogates the FTCA's intentional tort exception and therefore permits [the claimant's]suit against the United States alleging medical battery by a Navy doctor acting within the scope of his employment.'[110] The situation where the medical professional acts as a contractor is discussed below in conjunction with the action under the Alien Tort Statute.

Over the years, several civil suits have been brought against medical professionals involved in EITs in American detention centres. However, until April 2016, courts had rejected all such claims at early stages, and often immediately after filing. This is because they accepted the argument that, were the cases to proceed, they would endanger national security[111] by way of disclosure of confidential information.[112] The situation has changed with the release of the SSCI Report discussed in Chapter One. Even the condensed form, that is publicly available, has made available unclassified information that had previously been used to block lawsuits.

[110] *Levin* v *United States et al.* (2013) No. 11-1351.
[111] Indeed, *Salim* v *Mitchell* is the first case that was allowed to proceed.
[112] Anne Daugherty Miles, 'Perspectives on the Senate Select Committee on Intelligence (SSCI) "Torture Report" and Enhanced Interrogation Techniques: In Brief' (2015); Ruth Blakeley and Sam Raphael, 'Human Rights Fact-finding and the CIA's Rendition, Detention and Interrogation Programme: A Response to Cordell' (2017) 21 *International Area Studies Review* 169.

4.1. Claims under the Alien Tort Statute

Under US law, one can lodge a civil claim for damages for breaches of international law, under 28 USC § 1350 (Alien Tort Statute). The Alien Tort Statute is a unique piece of legislation that equips the US federal courts with jurisdiction over civil actions brought by foreign nationals (so-called aliens) for a tort where there is a violation of international law or a US treaty. According to the judgment in *Sosa* v *Alvarez-Machain*, violations of international norms must be 'specific, universal, and obligatory.'[113] Furthermore, the court in *Kiobel* v *Royal Dutch Petroleum Co.*, a case restricting the scope of the Alien Tort Statute, ruled that, generally, the statute does not apply to torts committed in foreign countries. However, the statute will be engaged where the claims 'touch and concern the territory of the United States… with sufficient force.'[114] As such, under the Alien Tort Statute, federal courts have the power to recognise a common-law cause of action for violations of human rights as long as they 'touch and concern the territory of the United States with sufficient force.'[115]

The lawsuit in *Salim* v *Mitchell*, filed under the Alien Tort Statute, alleged that two psychologists, Dr James E. Mitchell and Dr John Jessen, 'designed, implemented, and personally administered an experimental torture program for the [CIA].'[116] The complaint classified their acts as '(1) torture and cruel, inhuman, and degrading treatment; (2) non-consensual human experimentation; and (3) war crimes, all of which are violations of "specific, universal, and obligatory" international law norms, as evidenced by numerous binding international treaties, declarations, and other international law instruments.'[117] Their involvement cut across several of the kinds of behaviour identified in Chapter One: altering existing or developing new EITs (stage three of the taxonomy); advising on and tailoring EITs to a detainee (stage seven); or implementing EITs (stage ten). The claimants claimed to have

[113] *Sosa* v *Alvarez-Machain* (2004) 542 US 692.
[114] *Kiobel* v *Royal Dutch Petroleum Co.* (2013) 133 S. Ct. 1659.
[115] ibid.
[116] *Suleiman Abdullah Salim, et al.,* v *James E. Mitchell and John Jessen* (2018) Complaint, page 2, line 1. (Later cited as *Salim* v *Mitchell*).
[117] ibid page 7, line 7.

suffered severe physical, mental and emotional pain or suffering and sought compensatory, punitive and exemplary damages, along with costs.[118]

The civil suit was allowed to proceed; however, it was settled outside of court for an undisclosed amount. The settlement meant that no evidence was given in court and an opportunity to shed more light on the issue was missed. However, as there are multiple risks associated with litigation (including potentially high costs), such a settlement provides the applicants with some compensation for their injuries, pain or suffering without the litigation risk. Considering the early settlement, it is likely that similar cases may be brought forward, opening the possibility that more victims may secure compensation or, at the very least, evidence may be heard and examined in court.

Even though *Salim* v *Mitchell* ultimately settled, the defendants made several attempts to have the claim struck out on the basis that they should benefit from the state's immunity privilege. As this is an argument that may resurface in similar claims in the future, it is discussed here. Under the US law, CIA agents, as state actors, benefit from state immunity privilege.[119] Absolute immunity is a privilege available to:

> officials whose special functions or constitutional status requires complete protection from suit (…) The absolute immunity of legislators, in their legislative functions, and of judges, in their judicial functions, now is well settled. [A]bsolute immunity [is extended] to certain officials of the Executive Branch. These include prosecutors and similar officials, executive officers engaged in adjudicative functions, and the President of the United States.[120]

[118] Including, reasonable attorneys' fees and the costs of the legal action and other costs that may be just and proper.
[119] *Harlow* v *Fitzgerald* (1982) 457 US 800, 807.
[120] ibid.

However, absolute immunity is not available to executive officials or contractors.[121] While medical professionals are not eligible to benefit from this absolute immunity, they could find themselves within the purview of derivative sovereign immunity[122] which protects a government contractor from civil liability.[123] Indeed, here, the defendants argued that depending on the role undertaken, certain actors, for example, private citizens and contractors, who perform work on the government's behalf benefit from derivative sovereign immunity. As such, they are immune from suits. This was confirmed by the two leading US Supreme Court cases, *Yearsley* v *W.A. Ross Const. Co*.[124] and *Filarsky* v *Delia.*[125] In *Salim* v *Mitchell,* the court heard in-depth arguments on the issue, establishing a valuable precedent that could be persuasive in future cases. The below discusses the tests in these cases, the decision in *Salim* v *Mitchell,* and considers whether and how far they could be extended to medical professionals involved in EITs, other than those undertaking a similar role to Mitchell and Jessen (where it is highly likely that courts would follow the same approach).

The Test in Filarsky v *Delia*

Under the test established in *Filarsky,* a contractor may be immune from legal suits if 1) 'the contractor's claim for immunity is historically grounded in common law' and 2) 'did not violate clearly established rights.'[126] Pertaining to the historically grounded protections, in *Salim* v *Mitchell*, the defendants claimed that many medical professionals, and among others, psychiatrists and psychologists, benefit from immunity when they provide an opinion on the mental capacity of a defendant in criminal proceedings. The court found that *Filarsky* was not a helpful precedent on the issue, as medical professionals were not traditionally entitled to such immunity.[127] As the presiding judge, Judge Quackenbush, recognised, the defendants undertook a role significantly different from

[121] ibid. 'For executive officials in general, however, our cases make plain that qualified immunity represents the norm. We have acknowledged that high officials require greater protection than those with less complex discretionary responsibilities.'
[122] As opposed to absolute immunity.
[123] See: *Yearsley* v *W.A. Ross Const. Co.* (1940) 309 US 18; *Filarsky* v *Delia* (2012) 566 US 377.
[124] *Yearsley v W.A. Ross Const. Co.* (1940) 309 US 18. (Later cited as *Yearsley*)
[125] *Filarsky* v *Delia* (2012) 566 US 377. (Later cited as *Filarsky*)
[126] *Filarsky* v *Delia* (2012) 566 US 377, 19
[127] *Salim* v *Mitchell,* Memorandum Opinion Re: Motion for Summary Judgement, page 21, line 11.

that at stake in *Filarsky*, as they did not provide only an opinion but were the 'architects' of the EITs used. Hence, they should not be treated like medical professionals 'evaluating a criminal defendant and writing a report or testifying.'[128]

While in *Salim* v *Mitchell*, the first prong of the test in *Filarsky* failed because of the active role the defendants played in the use of EITs, which differed significantly from the claim for immunity that was historically grounded in common law, the test would likely produce different results in cases where medical professionals undertook less active roles. However, this does not necessarily mean that medical professionals who undertake less active roles would benefit from the defence. Their defence would, highly likely, fail on the second prong of the test, namely, that their actions violated a clearly established right. Indeed, in *Salim* v *Mitchell*, the court found that the defendants' actions in subjecting the complainant to torture and other cruel, inhuman or degrading treatment or punishment violated a clearly established right.[129] The court further found that a private contractor's immunity is qualified, not absolute, and it can be suspended 'if the defendant knew or *should have known* that his conduct violated a right clearly established at the time.'[130]

The Test in Yearsley v *W.A. Ross Const. Co.*

According to the test in *Yearsley*, a contractor acting according to 1) a 'validly conferred authority' and 2) 'within the scope of their contract', could benefit from derivative sovereign immunity defence.[131] While the test does not engage with this point, a related consideration is whether a criminal act can lawfully be delegated. Put differently, can the defence of derivative sovereign immunity protect individuals who conduct illegal acts, if those acts were authorised by the state? There are

[128] ibid line 2.
[129] *Salim* v *Mitchell,* Memorandum Opinion Re: Motion for Summary Judgement, page 21, line 15. See: *Filartiga* v *Pena-Irala* (1980) 630 F.2d876, 884: 'We conclude that official torture is now prohibited by the law of nations. The prohibition is clear and unambiguous and admits of no distinction between treatment of aliens and citizens.'
[130] *Campbell-Ewald* v *Gomez* (2016) 136 S. Ct. 663, 673. [Emphasis added]
[131] *Yearsley* v *W.A. Ross Const. Co.* (1940) 309 US 18: 'Where an agent or officer of the Government, purporting to act on its behalf, has been held to be liable for his conduct causing injury to another, the ground of liability has been found to be either that he exceeded his authority or that it was not validly conferred.' See also: *Salim* v *Mitchell,* Memorandum Opinion Re: Motion for Summary Judgement, page 20, line 8.

strong policy reasons against accepting that a government could delegate an act that is criminal and by doing so immunise the person conducting the activity. Indeed, allowing such an argument would provide a loophole for governments to authorise others to commit crimes on their behalf with impunity. Furthermore, the judgment in *Yearsley* states that the immunity relates to civil suits and is not a defence from any other form of accountability, for example, criminal accountability.[132] Therefore, the court's analysis only considers acts that are not criminal.

Once authority is validly conferred, it needs to be asked whether the contractor acted within or exceeded his authority.[133] Judge Quackenbush reasoned that derivative sovereign immunity can be relied upon only where the contractor 'had no discretion in the design process and completely followed government specifications.'[134] While the defendants claimed that they 'acted only at the direction of the CIA, that the CIA was "responsible", or that the CIA had full operational control,'[135] the evidence before Judge Quackenbush clearly demonstrated that the defendant designed and implemented the experimental EIT program.[136] Taking into consideration the involvement of the two defendants, Judge Quackenbush thus found that 'although the CIA may have maintained ultimate control of the Program, Defendants [Mitchell and Jessen], being on-site, exercised significant control during individual interrogations.'[137] They did not act 'merely and solely as directed by the Government'[138] and 'have not established they merely acted at the direction of the Government, within the scope of their authority.'[139] Judge Quackenbush thus found that the test in *Yearsley* had not been met. It is highly likely that medical professionals involved in EITs in American detention centres, and especially those undertaking roles akin to those of Mitchell and Jensen who designed the

[132] *Yearsley* v *W.A. Ross Const. Co.* (1940) 309 US 18, 12.
[133] *Campbell-Ewald* v *Gomez* (2016) 136 S. Ct. 663, 673: 'Where the Government's "authority to carry out the project was validly conferred, that is, if what was done was within the constitutional power of Congress," we explained, "there is no liability on the part of the contractor" who simply performed as the Government directed. The Court contrasted with *Yearsley* cases in which a Government agent had "exceeded his authority" or the authority "was not validly conferred"; in those circumstances, the Court said, the agent could be held liable for conduct causing injury to another.' [internal citations omitted]
[134] *Cabalce* v *Thomas E. Blanchard & Associates* (2015) 797 F.3d 720, 732.
[135] *Salim* v *Mitchell*, Memorandum Opinion Re: Motion for Summary Judgement, page 22, line 24.
[136] ibid line 25.
[137] ibid page 25, line 5.
[138] ibid page 24, line 26.
[139] ibid line 18.

EITs and implemented them, could not rely on the defence in *Yearsley*. However, this may differ from other medical professionals who undertook less active roles.

The settlement in *Salim* v *Mitchell* gives some grounds for cautious optimism that similar future lawsuits may succeed. Commenting on the case, Raymond maintains that: 'allowing these cases to proceed on their merits both provides a remedy for injured parties and creates a further disincentive to stray from prescribed orders.'[140] However, this does not mean that the immunity denied to these two doctors will necessarily be unavailable for all medical professionals involved in EITs in American detention centres. The derivative sovereign immunity may benefit only those medical professionals who act as an agent to the state and within the scope of their contract.[141] As Weis argues, 'paramount concern in immunity questions is the function the defendant performs, rather than the defendant's title or status.'[142] Hence, this thesis argues that a distinction needs to be made between medical professionals who have been exercising a degree of discretion by way of, for example, designing new or altering existing EITs (as under stage three of the taxonomy) or advising on and tailoring EITs to a specific detainee (stage seven), from other cases where medical professionals may not have been able to exercise this degree of discretion. This further reflects the decision of the Supreme Court in *Campbell-Ewald Co.* v *Gomez,* which found that 'a federal contractor who simply performs as directed by the Government may be shielded from liability for injuries caused by its conduct.'[143]

Nonetheless, it is critical to recognise the challenges for those who would seek to extend this defence to medical professionals. When providing medical care to their patients, doctors would rarely be able to follow government specifications, rather they would require a level of discretion (or independence in medical decision making) to adjust the medical care to the needs of the patients and to act in their

[140] Kelcey Raymond, 'Merits Matter: Qualifying Government Contractor Immunity' (2019) 48 *Public Contract Law Journal* 841, 856.
[141] ibid 856.
[142] Andrew W. Weis, 'Qualified Immunity for Private Sector Defendants after *Filarsky* v *Delia*' (2014) 30 *Georgia State University Law Review* 1037, 1075.
[143] *Campbell-Ewald* v *Gomez* (2016) 136 S. Ct. 663, 666.

best interest. Arguably, under stage two of the taxonomy (monitoring the use of EITs), medical professionals could act only within the scope of the conferred authority, and so, potentially, benefit from the defence in *Yearsley*. Similarly, stage nine (withdrawing or withholding basic medical care) may fall within the scope of the defence. However, even here, the availability of the defence would depend on whether medical professionals have the discretion to decide in which cases they could withdraw or withhold medical care, or whether they are merely given orders and act upon them. All other stages of the taxonomy would require a degree of independence and discretion that is highly likely incompatible with the requirement for the defence to apply.

Furthermore, derivative sovereign immunity is not granted automatically to a government contractor.[144] The court in *Campbell-Ewald* v *Gomez* found that '[w]hen a contractor violates both federal law and the Government's explicit instructions… no "derivative immunity" shields the contractor from suit by persons adversely affected by the violation.'[145] Jason Malone, professor of law, notes that when extending immunity to contractors, 'a balance must be made between the potential harm done to the claimant and the interest of the sovereign to effectuate government.'[146] This follows the finding in *Doe* v *McMillan* where the court concluded that immunity is appropriate only when 'the contributions of immunity to the elective government in particular contexts outweigh the perhaps recurring harm to individual citizens.'[147] Malone suggests that derivative immunity is a 'necessity for the functioning of an effective government.'[148] Indeed, the risk of litigation could prevent many experienced and skilled contractors from undertaking such government contracts. This follows the argument in *Filarsky* where the court found that:

> The government, in need of specialised knowledge or expertise, may look outside its permanent workforce to secure the services of private individuals. But because those

[144] ibid.
[145] ibid 672.
[146] Jason Malone, 'Derivative Immunity: The Impact of *Campbell-Ewald Co.* v *Gomez*' (2016) 50 *Creighton Law Review* 87, 123.
[147] *Doe* v *McMillan* (1973) 412 US 306, 320. See also: *Murray* v *Northrop Grumman Info. Tech. Inc.* (2006) 444 F.3d 169, 175.
[148] Malone (n 146) 124.

> individuals are free to choose other work that would not expose them to liability for government actions, the most talented candidates might decline public engagements if they did not receive the same immunity enjoyed by their public employee counterparts.[149]

Considering the above, and the findings in *Salim* v *Mitchell*, it is very unlikely that medical professionals would be able to rely on the defence of derivative sovereign immunity, other than in very limited cases where the action is not criminal in nature and the contractor does not exercise significant control over how it is performed. Notably, the defence of derivative sovereign immunity applies to all civil claims and not only those made under the Alien Torts Statute.

Civil suits under the Alien Tort Claims Act, despite providing compensatory relief, differ from claims in tort brought under domestic law.[150] However, no claims in tort have been brought against medical professionals involved in EITs. Because actions under the Alien Tort Statute allege war crimes committed by medical professionals, the pleadings do not plead issues that would have ordinarily been considered in other civil suits. The below discusses the two other main civil avenues for breach of the fiduciary relationship and negligence (medical malpractice).

4.2. A Claim for Breach of the Fiduciary Relationship

Where a medical professional is in a fiduciary relationship with the patient, the medical professional can be held to account for a breach of their fiduciary duties. The possible relief for such claims includes compensation, restitution[151] and also punitive damages.[152] The action is meant to put a patient in 'a stronger legal position in the event of a breach',[153] offsetting 'a weaker interpersonal position in the fiduciary relationship.'[154] As Matthew notes 'procedurally, fiduciary law places a

[149] *Filarsky* v *Delia* (2012) 566 US 377, 1659.
[150] *Sosa* v *Alvarez-Machain* (2004) 542 US 692; *Kiobel* v *Royal Dutch Petroleum Co.* (2013) 133 S. Ct. 1659.
[151] Gordon Smith (n 24)1405-6.
[152] E. Haavi Morreim, 'Medicine Meets Resource Limits: Restructuring the Legal Standard of Care' (1997) 59 *University of Pittsburgh Law Review* 71.
[153] Mehlman (n 24) 1137.
[154] ibid.

reduced burden of proof upon claimants in making out a *prima facie* case',[155] with the claimant required merely to show that the fiduciary relationship existed and was breached.[156] While the patient would need to provide evidence of the breach, the burden then shifts onto the medical professional to challenge the allegation.[157] Indeed, as Mehlman notes, in breach of fiduciary duty cases, the burden-shift 'resembles *res ipsa loquitor* cases, where in some jurisdictions, once the claimant shows that the accident ordinarily would not occur unless the defendant had been negligent, the burden shifts to the defendant to prove that he did not make an unreasonable mistake.'[158] The threshold to be met by the defendant is one of 'clear and convincing evidence.'[159] In actions for breach of fiduciary duties, the breach in itself is actionable.[160] The proof of actual injury is not always necessary,[161] although this differs between states,[162] and 'many states do not have a causation requirement.'[163]

Considering the lower threshold for claims for breach of the fiduciary duties,[164] the existence of a fiduciary relationship could radically improve the chances of successfully holding doctors to account in civil law.[165] For the claim to succeed, among other aspects, the claimant would have to show a conflict of interest, e.g. that the medical professional pursued self-interest or any other interest rather than prioritising the patient's care (and patient's best interest).[166] Such a conflict is only one basis for establishing breach.

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[155] Dayna Bowen Matthew, 'Implementing American Health Care Reform: The Fiduciary Imperative' (2011) 59 *Buffalo Law Review* 715, 735; Brian M. Serafin, 'Comparative Fault and Contributory Negligence as Defences in Attorney Breach of Fiduciary Duty Cases' (2008) 21 *Georgetown Journal of Legal Ethics* 993, 994-995.
[156] Bowen Matthew (n 155) 735; Restatement (Third) of Torts §8.01 d (1) (2006).
[157] *Demers* v *Gerety* (1978) 85 N.M. 641, 655. See also: Knaebel v Heiner (1983) 663 P.2d 551, 553; *Smith v Tele-Commc'n, Inc.* (1982) 184 Cal. Rptr. 571, 575; *Konover Dev. Corp.* v *Zeller* (1994) 635 A.2d 798, 810; *Labovitz* v *Dolan* (1989) 545 N.E.2d 304, 311; *Sampson* v *Hunt* (1983) 665 P.2d 743, 754; *Gaynier* v *Ginsberg* (1986) 715 S.W.2d 749; *Wilkins* v *Lasater* (1987) 733 P.2d 221, 228.
[158] Mehlman (n 24) 1151. See also: Restatement (Second) of Torts §328D (1965).
[159] ibid.
[160] Thomas L. Hafemeister and Sarah Payne Bryan, 'Beware Those Bearing Gifts: Physicians' Fiduciary Duty to Avoid Pharmaceutical Marketing' (2009) 57 *University of Kansas Law Review* 491, 524.
[161] Bowen Matthew (n 155) 735; Serafin (n 408) 994-995.
[162] *Milbank, Tweed, Hadley & McCloy* v *Boon* (1994) 13 F.3d 537, 543; *Zackiva Commc'ns Corp.* v *Horowitz* (1993) 826 F. Supp. 86, 88; *Diamond* v *Oreamuno* (1969) 248 N.E.2d 910. 912; *Rice* v *Perl* (1982) 320 N.W.2d 407, 411.
[163] Hafemeister and Payne Bryan (n 160) 524.
[164] Bowen Matthew (n 155) 994-995. See also: Phyllis Coleman, 'Sex Between Psychiatrist and Former Patient.: A Proposal for a "No Harm, No Foul" Rule' (1988) 41 *Oklahoma Law Review* 23-27.
[165] ibid.
[166] Mehlman (n 24) 1137. See also: Gregory D. Jones, '*Primum Non Nocere*: The Expanding "Honest Services" Mail Fraud Statute and the Physician Patient Fiduciary Relationship' (1998) 51 *Vanderbilt Law Review* 139, 172.

In defence, the medical professional can claim that there was no fiduciary relationship, an argument heavily relied upon by the US Administration but rebutted in Chapter Four. As has been demonstrated, a fiduciary relationship can be established across the majority of stages of the taxonomy of medical involvement in EITs, meaning that this argument would not be available to a medical professional. Second, a medical professional could attempt to demonstrate that there was no 'unreasonable mistake that harmed the patient's health or that the unreasonable mistake was not caused by the physician placing his own self-interest before the patient's.'[167] The question would then become what amounts to an 'unreasonable mistake' in all the circumstances and, further, whether this was due to self-interest or just carelessness. Self-interest is most easily demonstrated where medical professionals are motivated by financial gain.[168] However, not every financial gain will qualify here and D. Gordon Smith, professor of law, argues that it is 'opportunism' which is the deciding factor and, 'courts vary the intensity of fiduciary duty in ways that tolerate more or less self-interested behaviour by fiduciaries. The potential for opportunism depends on the likelihood of harm and the potential magnitude of the harm.'[169] Mehlman suggests that the existence of self-interest would need to be established by expert testimony to confirm that:

> the mistake was not a breach of fiduciary duty - for example, that it was an honest mistake caused by inadvertence - or that the incentive alleged to have made the physician act dishonourably was not significant enough to have had that effect.[170]

While the claimant does not have to demonstrate proof of the actual injury, this would not have been an issue in the case study.

On the basis of the existing jurisprudence, it is clear that pursuing an action for breach of fiduciary duty provides a feasible option for holding doctors accountable. Nonetheless, currently, no reported

[167] Mehlman (n 24) 1151.
[168] For example, *Strauss* v *Biggs* (1987) 525 A.2d 992, 998; *Davis* v *Superior Court* (1994) 33 Cal. Rptr. 2d 6, 9.
[169] Gordon Smith (n 24) 1484.
[170] Mehlman (n 24) 1151.

cases rely on this route towards accountability. This may be because this avenue does not appeal to potential claimants, it might be perceived to respond ineffectually to the severity of the acts perpetrated, as compared to, for example, the actions available under the Alien Tort Statute, which are based on allegations of serious crimes under international law. It may also be that some victims are not aware of this option. In the only successful claim under the Alien Tort Statute, it was not the victims but the lawyers who actively pursued the case, having identified the claimants and respondents from the SSCI report. After the launch of the SSCI report, and having reviewed the documents, ACLU lawyers identified the victims, the defendants and the evidence required to proceed with the claim. They also acted *pro bono* to assist the victims to bring the cases forward. This will not be the case for every victim and every legal avenue. Furthermore, it might be the case that others have been convinced by the US Administration's argument that there is no fiduciary relationship between medical professionals and detainees, so have not pursued this option for that reason.

Lastly, another reason may be that there are certain jurisdictional limitations, depending on where the breach of the fiduciary duty occurred. The state (as a federal unit) with jurisdiction will be the state that has 'the most significant relationship' to the claim for breach of fiduciary duty.[171] As such, a lack of jurisdiction would prevent actions for breach of the fiduciary relationship. Notwithstanding these formidable hurdles, this action offers an important possible avenue of recourse that deserves to be tested in the courts.

4.3. An Action for Medical Malpractice

A claim in medical malpractice is a tort claim whereby the claimant seeks damages for substandard medical treatment that results in his or her suffering harm.[172] The outcome of medical malpractice cases depends on the claimant being able to prove the existence of a legal duty of care[173] (which flows

[171] See Restatement (Second) of Conflict of Laws § 145(1).
[172] Nathalie De Fabrique, 'Medical Malpractice' in Jeffrey S. Kreutzer, John DeLuca, and Bruce Caplan (eds.), *Encyclopedia of Clinical Neuropsychology* (Springer: New York, 2011) 114. See also: Sonny Bal (n 73) 342.
[173] *Ortiz* v *Glusman* (2011) 334 S.W.3d 812.

from the doctor-patient fiduciary relationship discussed in Chapters Three and Four), a breach of that duty by failing to treat in accordance to the standards of the profession,[174] causation between the breach and injury to the patient,[175] and damages flowing from the injury, whether compensatory damages, non-economic damages or punitive damages.[176]

The US Administration's argument that there is no fiduciary relationship between medical professionals and detainees attacks the very first element of a claim for medical malpractice, the existence of the duty. As Chapter Four shows, the existence of the duty, and a fiduciary relationship, can be established. Nonetheless, the remaining elements of such a claim may be problematic. Establishing a breach of the duty will depend on the ability to show that the treatment or care provided to the patient fell below the standard of care, and thus will be dependent on expert evidence.[177] While the standard of care will vary from state to state, there is substantial common ground between them, as Meyer and Price suggest: 'in medical malpractice, the applicable standard of care is that of the average prudent [medical professional] in similar circumstances.'[178] Causation between the breach and injury to the detainee would also need to be established,[179] for example, based on an expert opinion. Damages flowing from the injury may include pain and suffering, and financial loss. Compensation will normally remediate those damages, in addition, punitive damages may be available where the medical professional was involved in an intentional tort or wanton and wilful conduct.[180]

There have been no reported medical negligence actions against medical professionals in American detention centres. Nonetheless, the issue of negligent treatment has been raised in court, although not ruled upon. In the case of *Jihad Dhiab* v *Barack Obama*, Abu Wa'el (Jihad) Dhiab filed a petition for

[174] *Valencia* v *United States* (1993) 819 F. Supp. 1446.
[175] *Bramlette* v *Charter Medical-Columbia* (1990) 302 S.C. 68, 393 S.E.2d 914.
[176] Sonny Bal (n 73) 342.
[177] ibid.
[178] Meyer and Price (n 75) 193.
[179] *Bramlette* v *Charter Medical-Columbia* (1990) 302 S.C. 68, 393 S.E.2d 914.
[180] *National By-Products Inc.* v *Searcy House Moving Co.* (1987) 731 S.W.2d 194.

a writ of *habeas corpus* to prevent the government from force-feeding him.[181] During hearings that engaged with the practice of force-feeding, an independent medical expert, Dr Sandra Crosby, testified on the provision of medical care to the detainee more generally. She claimed that 'it look[ed] like medical care [was] being withheld' from Dhiab, in her belief, because of his disciplinary status.[182] Crosby also identified that the medical professionals in Guantanamo Bay had failed to conduct necessary medical testing and an examination regarding the source of Dhiab's back problem, which would have allowed them to treat it adequately, to ease the symptoms and prevent exacerbation.[183] The description of the care afforded to Dhiab is suggestive of substandard medical care that should be sufficient to trigger medical negligence proceedings.

Where the avenue is available, there are relative merits of an action in tort in comparison with disciplinary action, although both can be pursued in parallel. As Dineen and DuBois note, 'civil liability in medical malpractice can result from even one deviation from the standard of care' while 'professional discipline usually requires some degree of a pattern of inappropriate practice.'[184] Additionally, while 'one material and sufficient deviation from the standard of care may create liability',[185] according to Sandra H. Johnson, professor of law and health care ethics, 'the profession's prevailing custom, with some substantial tolerance for "respectable minority" views, has been the gold standard for scrutinising physician practice and treatment decisions in the malpractice context.'[186] This is in contrast to disciplinary proceedings where 'the standard of care to which the member physician is held in the code of conduct adopted by the organisation.'[187] In certain cases of

[181] *Jihad Dhiab* v *Barack Obama et al.* (2017).
[182] Carol Rosenberg 'US Attorney Defends Guantánamo Hunger Striker's Forced-Feedings' *Miami Herald* (6 October 2014).
[183] ibid.
[184] Dineen and DuBois (n 14).
[185] Dineen and DuBois (n 14). See also: Ben A. Rich and Lynn R. Webster, 'A Review of Forensic Implications of Opioid Prescribing with Examples from Malpractice Cases Involving Opioid-Related Overdose' (2011) 12 *Pain Medicine* S59, S62.
[186] Sandra H. Johnson, 'Customary Standard of Care: A Challenge for Regulation and Practice' (2013) 43 *Hastings Centre Report* 6, 9.
[187] Meyer and Price (n 75) 194. See also: Donald J. Meyer, Robert I. Simon, and Daniel W. Shuman, 'Professional Liability in Psychiatric Practice and the Requisite Standard of Care' in Robert I. Simon and Liza H. Gold (eds.), *Textbook of Forensic Psychiatry* (American Psychiatric Publishing: Washington DC, 2010) 207–26.

particularly egregious breaches, the breach may be captured within the purview of *res ipsa loquitur*.[188] The breach must cause injury and harm to the patient and damages must be suffered as a result.[189] This, depending on the stage of the taxonomy, may become problematic, especially in establishing causation between the breach of the duty and the injury.

As with an action for breach of a fiduciary relationship, one of the issues with pursuing an action under this heading may be that it appears not to reflect the severity of the alleged conduct. One would expect that any involvement in EITs that amount to criminal conduct should trigger more serious legal consequences, for example, criminal proceedings. However, where such criminal proceedings are not possible, civil avenues for legal recourse could provide the victims with some redress.

5. Criminal Proceedings

Criminal proceedings require a higher standard of wrongdoing than professional misconduct, although some professional misconduct may trigger criminal proceedings.[190] Criminal proceedings against medical professionals are common in, for example, cases of sexual abuse, insurance fraud, or illegal use of prescription drugs.[191] As some of the actions undertaken by doctors in connection to EITs will amount to criminal conduct, it is crucial to consider the US domestic options available to bring medical professionals to account. To date, while allegations of medical professionals' involvement in EITs have resulted in disciplinary complaints and tort action, no criminal action has been brought. This may reflect the assurances that EITs were legal: even after the SSCI report, the US Administration refused to acknowledge that EITs amounted to criminal conduct. While accepting that a few individuals may have been involved in criminal activity, it refused to accept that this was

[188] Sonny Bal (n 73) 342; Leonard Berlin, 'Malpractice Issues in Radiology: *Res Ipsa Loquitur*' (2009) 193 *American Journal of Roentgenology* 1475.
[189] Gregg J. Gittler and Ellie J. Goldstein, 'The Elements of Medical Malpractice: An Overview' (1996) 23 *Clinical Infectious Diseases* 1152, 1155.
[190] Barker (n 17) 1321; George J. Annas, 'Medicine**,** Death and the Criminal Law' (1995) 333 *New England Journal of Medicine* 527.
[191] See for example: *Ballard* v *Superior Court* (1966) 410 P.2d 838; *People* v *Middleton* (1976) 350 N.E.2d 223; *Eberhart* v *State* (1893) 34 N.E. 637. See also: Deborah Sprenger, 'Propriety of Instruction of Jury on "Conscious Avoidance" of Knowledge of Nature of Substance or Transaction in Prosecution for Possession or Distribution of Drugs' (1992) 109 *American Law Reports, Federal* 710, 713, § 2[a].

a systemic issue. Several potential actions in criminal law might be pursued at a domestic level and these are discussed below.

5.1. Actions for Criminal Negligence

Medical professionals could be prosecuted in US domestic courts for their involvement amounting to torture[192] or other criminal conduct. In such cases, the medical professionals' liability would exist independent of the existence of the fiduciary relationship. However, the existence of such a relationship may result in an increased sentence.[193] Furthermore, even in certain cases where the acts are not ordinarily criminal, they may nonetheless be rendered so where a fiduciary relationship is present. One common example would be a breach of the fiduciary duty to act in the best interest of the patient (amounting to gross negligence) which results in the death of the patient, whether by an act or omission (criminally negligent manslaughter or criminally negligent homicide).[194] A medical professional can be prosecuted for gross negligence manslaughter only where there is a fiduciary relationship (otherwise they would be under no duty to provide medical care to the patient and an action in gross negligence manslaughter would fail).

Legal recourse for medical malpractice is discussed in Section 4.3. above. However, medical malpractice, apart from attracting civil liability, may also result in criminal accountability, as is the case with criminal negligence. Medical professionals have been convicted of a variety of criminal offences, including criminal negligence manslaughter, abuse, and reckless endangerment, all three relevant to the case study of this thesis. The *mens rea* and *actus reus* requirement under state law

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[192] 18 USC § 2340A*:* (a) Offense. Whoever outside the United States commits or attempts to commit torture shall be fined under this title or imprisoned not more than 20 years, or both, and if death results to any person from conduct prohibited by this subsection, shall be punished by death or imprisoned for any term of years or for life.(b) Jurisdiction.—There is jurisdiction over the activity prohibited in subsection (a) if—
(1) the alleged offender is a national of the United States; or
(2) the alleged offender is present in the United States, irrespective of the nationality of the victim or alleged offender.
18 USC § 2340*:* '(1) "torture" means an act committed by a person acting under the colour of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control.'

[193] Jones (n 166) 172; John C. Coffee, Jr., 'From Tort to Crime: Some Reflections on the Criminalisation of Fiduciary Breaches and the Problematic Line Between Law and Ethics' (1981) 19 *American Criminal Law Review* 117, 126.

[194] T.B. Barlow, 'Medical Negligence Resulting in Death' (1948) 11 *Journal of Contemporary Roman-Dutch Law* 173.

actions for criminal negligence vary from state to state and continues to cause debates.[195] Monico *et al* suggest that 'criminal negligence is more than a mistake in judgment.'[196] Similarly, Eisenberg and Berlin add that 'most jurisdictions hold that something more than ordinary negligence must be proven before the defendant can be found guilty of involuntary manslaughter.'[197] Indeed, courts dealing with the issue have moved in the direction of recognising gross negligence or carelessness,[198] recklessness and wanton behaviour[199] or acting 'without due caution and circumspection'[200] as necessary elements. Similarly, Black's Law Dictionary defines criminal negligence as 'gross negligence so extreme that it is punishable as a crime',[201] moving beyond the definition of medical negligence in civil law discussed in Section 4.3. The test is nonetheless poorly defined, with vague determining criteria.

Criminal negligence manslaughter, whether classified as second-degree murder, reckless manslaughter (negligent homicide) or involuntary manslaughter, all of which are defined in law, whether in the Model Penal Code ('MPC') or common law, concern cases where a medical professional provides substandard care or treatment that results in the patient's death. For example, a few obstetricians have been convicted of reckless manslaughter and criminally negligent homicide, murder, and involuntary manslaughter of women for whom they performed negligent abortions.[202] An anaesthesiologist was convicted of reckless manslaughter for falling asleep during a surgery.[203] A surgeon was convicted of involuntary manslaughter for administering an overdose of a drug.[204] Similarly, an anaesthesiology resident was charged with involuntary manslaughter for improperly

[195] Monico *et. al*. (n 23) 2; Ronald L. Eisenberg and Leonard Berlin, 'Malpractice Issues in Radiology: When Does Malpractice Become Manslaughter?' (2002) 179 *American Journal for Roentgenology* 331, 333; James A. Filkins, '"With No Evil Intent": The Criminal Prosecution of Physicians for Medical Negligence' (2001) 22 *Journal of Legal Medicine* 471, 472.
[196] Monico *et. al*. (n 23) 2.
[197] Eisenberg and Berlin (n 195) 333.
[198] *Fitzgerald* v *State, Ala.* (1896) 34, 20 So. 966: 'That degree of negligence or carelessness which is denominated as gross, and which constitutes such a departure from what would be the conduct of an ordinarily careful and prudent man… as to furnish evidence of that indifference to consequences which in some offenses takes the place of criminal intent.'
[199] *State* v *Weiner* (1964) 21, 194 A.2d 467: 'Negligence, to be criminal, must be reckless and wanton.'
[200] *People* v *Stuart* (1956) 302 P.2d 5, 9.
[201] Bryan A. Garner, *Black's Law Dictionary* (Thomson-West Publishing Company, 2004) 1134. See also: Dineen and DuBois (n 14) 7; Kim (n 14) 532.
[202] Lynette Holloway, 'Abortion Doctor Guilty of Murder' *New York Time* (9 August 1995); Verena Dobnik, 'Doctor in Badly Botched Abortion is Tried for Manslaughter' *Associated Press* (2 May 2018).
[203] Associated Press, 'Anaesthesiologist Found Negligent in Boy's Death' *The New York Times* (24 October 1996).
[204] Anthony Thornton, 'Surgeon Was Negligent in Death, Jury Decides' *The Oklahoman* (12 May 1998).

administering an antibiotic.[205] While in all these cases, the medical professionals were convicted of criminal negligence manslaughter, as their acts or omissions have resulted in the death of their patients, the offences differ to reflect the different elements of each offence, including the *mens rea* requirement. Medical professionals in American detention centres may find themselves within the purview of the criminal negligence manslaughter offence across all stages of the taxonomy where their acts result in the death of the patients. Such an action would be particularly plausible where medical professionals are involved in life-threatening acts, for example, force-feeding of detainees (stage eight), withholding or withdrawing medical care (stage nine) or use of EITs on detainees (stage ten).

Abuse of patients may also result in other criminal charges. For example, a surgeon was charged with second-degree adult abuse[206] at two nursing homes for physically abusing vulnerable patients.[207] The definition of abuse differs between states.[208] However, across the laws of different states, the definition of abuse incorporates the same fundamental elements of 'wilful, intentional, reckless, non-accidental, and non-therapeutic infliction of physical pain, injury or mental distress.'[209] While the precise *mens rea* may vary, it is the element of 'nontherapeutic infliction of physical pain, injury or mental distress' that is significant here. The offence of abuse is relevant across many stages of the taxonomy (apart from, for example, stage one of providing basic medical care) as such involvement in EITs, would, highly likely, fall within the purview of the legal definition above.

Lastly, the offence of reckless endangerment of a patient is of relevance. In one of the reckless endangerment cases, *The People* v *Einaugler*, a medical professional, specialising in internal

[205] ibid.
[206] §750.145n of the Michigan Complied Laws states '(2) A caregiver or other person with authority over the vulnerable adult is guilty of vulnerable adult abuse in the second degree if the reckless act or reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes serious physical harm or serious mental harm to a vulnerable adult.' §750.145 defines caregiver as an individual directly caring for or has physical custody of a vulnerable adult.
[207] Tanya Albert, 'Malpractice or Murder? Criminalisation of Medical Errors is a Troubling Trend' *American Medical News* (22 October 2001).
[208] Lora Flattum Hamp, 'Analysis of Elder Abuse and Neglect Definitions Under State Law' in Richard J. Bonnie, Robert B. Wallace, *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America* (National Academies Press: Washington DC, 2003).
[209] ibid.

medicine, was convicted (by a jury) of reckless endangerment of a patient and wilful violation of health laws.[210] The Court of Appeal upheld the jury verdict, clarifying the premise of reckless endangerment to cover situations where:

> the defendant was aware of, and consciously disregarded, a substantial risk of serious physical injury to the patient… and that his conduct constituted a gross deviation from the standard of conduct a reasonable person would observe in the situation.[211]

While in the case, the act in question referred to delaying the patient's transfer to a hospital, the jurisprudence it established is of significance to the case study of this thesis. Indeed, it may be argued that, across all stages of the taxonomy, although to different degrees and in different ways, medical professionals involved in EITs were 'aware of, and consciously disregarded, a substantial risk of serious physical or mental injury to detainees.' Such involvement in EITs would likely constitute a gross deviation from the standard of conduct. A question of what conduct might be expected of a medical professional in a detention camp could not reasonably lead to a conclusion that a medical professional may engage in activities that recklessly endanger detainees. This would not be the case where medical professionals provide them with medical care aimed at protecting their best interests.

In *The People* v *Einaugler*, the medical professional was further convicted of a misdemeanour; wilful violation of health laws which prohibit 'an act of neglect', defined as 'failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a patient or resident of a health care facility.'[212] The Court of Appeal commented upon the issue of the *mens rea* necessary for the offence of 'violating public health laws requires a showing of more than simple negligence in the exercise of clinical medical judgment, but rather requires proof of a "wilful" failure to provide timely, consistent, safe, adequate, and appropriate treatment and/or care.'[213] Leonard Berlin, professor of

[210] Annas (n 190) 527; M. Crane, 'Practice Medicine, Land in Jail' *Wall Street Journal* (21 February 1995).
[211] *The People* v *Einaugler* (1994) 618 NYS2d 414.
[212] ibid.
[213] ibid.

medicine, argues that 'although responsible [medical professionals] have nothing to fear from the criminal law… [medical professionals] who intentionally or recklessly disregard the patient's safety may properly face criminal prosecution.'[214] Again, the offence of reckless endangerment would be of relevance across almost all stages of the taxonomy. Indeed, it may be argued that, medical professionals involved in EITs, both disregard patient's safety and the known and substantial likelihood of an injury to a patient.

While the above three offences are most important to the case study of this thesis, other criminal offences may also be relevant: a failure to treat, breach of confidentiality, and falsifying medical data. For example, a medical professional in the US was sanctioned for failure to treat a patient in an emergency (and also for falsifying medical records).[215] Similarly, a breach of confidentiality (which is a breach of fiduciary relationship) can amount to a crime. A medical professional criminally violates the Health Insurance Portability and Accountability Act (HIPAA) if he or she is involved in 'knowingly obtaining or using HIPAA-protected information without authorisation.'[216] Indeed, in one recent case, classified as a criminal breach of confidentiality under the HIPAA,[217] a medical professional was convicted for providing a pharmaceutical salesperson with access to his patient's medical records to assist with persuading the insurer to pay for the drugs.[218] Breach of the fiduciary relationship by way of falsifying medical data may also result in criminal charges. For example, a medical professional was convicted of knowingly and wilfully preparing and delivering two false medical reports to the US Immigration and Naturalisation Service.[219] This constituted a breach of his duty to report truthfully and accurately, which is a crime.[220] Furthermore, the existence of the

[214] Leonard Berlin, 'Consequences of Being Accused of Malpractice' (1997) 169 *Journal of Roentgenology* 1219, 1222. Annas (n 190) 527.
[215] Paul Jung, Peter Lurie and Sidney M. Wolfe, 'US Physicians Disciplined for Criminal Activity' (2006) 16 *Journal of Law and Medicine* 335.
[216] Anne M. Murphy, Laura B. Angelini and Jared Shwartz, 'Criminal Prosecution for Violating HIPAA: An Emerging Threat to Health Care Professionals' *STAT News* (2 July 2018).
[217] HIPAA provides for disciplinary, civil and criminal consequences.
[218] Marianne Kolbasuk McGee, 'Former Physician Convicted of Criminal HIPAA Violation' *Careers Info Security* (4 May 2018).
[219] Jung *et al.* (n 215) 335.
[220] ibid.

fiduciary relationship is of importance to sentencing, where it may trigger a higher sentence when compared to cases where there is no such relationship.[221] This reflects the special nature of the relationship between the parties.

However, cases relating to medical professionals raises certain questions concerning *mens rea*. Does the medical professional have the required *mens rea* to be criminally liable for the acts in question? While the above criminal offences prescribe different *mens rea* requirement, Hoffmann claims that not all types of *mens rea* may be appropriate for criminal prosecutions, even if the law allows such prosecutions.[222] Indeed, she claims that while criminal prosecutions for intentionally or knowingly violating the law are commonly agreed, criminal prosecutions for conduct carried out recklessly or negligently may not be justified.[223] Her claim is at odds with US domestic law,[224] which acknowledges that there are different kinds of *mens rea* and accepts the established principle that ignorance of the law is no excuse.[225] While, generally, ignorance of the law is no defence, nonetheless, this thesis considers Hoffmann's claim as a relevant consideration in this case study. Here, medical professionals may be considered to have unintentionally violated the law if they relied on the Office of Legal Counsel's legal opinions discussed in Chapter Two. As such, according to MPC 2.02(2) they may find themselves within the purview of the *mens rea* of recklessly or negligently[226] and they could

[221] Erich D. Andersen, 'Enhancement for Abuse of a Position of Trust under the Federal Sentencing Guidelines' (1991) 70 *Oregon Law Review* 181; Perter Cashman, 'Medical Benefit Fraud: Prosecution and Sentencing of Doctors, Part 1' (1982) 7 Legal Services Bulletin 58.
[222] Diane E. Hoffmann, 'Physicians Who Break the Law' (2009) 53 *Saint Louis University Law Journal* 1049, 1079.
[223] ibid.
[224] See: Model Penal Code.
[225] Indeed, the courts confirmed this principle of *ignorantia juris non excusat* in the leading case on the issue, namely, *Jerman* v *Carlisle, McNellie, Rini, Kramer and Ulrich LPA et al.* In *Jerman* v *Carlisle, McNellie, Rini, Kramer and Ulrich LPA et al.*, Justice Sotomayor found that 'ignorance of the law will not excuse any person, either civilly or criminally.' *Jerman* v *Carlisle, McNellie, Rini, Kramer and Ulrich LPA et al.* (2010) 559 US 573. However, in *Lambert* v *California*, the court found that 'where a person did not know of the duty to register and where there was no proof of the probability of such knowledge, he may not be convicted consistent with due process.' *Lambert* v *California* (1957) 355 US 225. Similarly, in *Cheek* v *United States*, the court decided that the despite the general rule, some laws, as for example, tax laws, are too complex and hence 'Congress has accordingly softened the impact of the common law presumption by making specific intent to violate the law an element of certain federal criminal tax offenses. Thus, the Court almost 60 years ago interpreted the statutory term 'wilfully' as used in the federal criminal tax statutes as carving out an exception to the traditional rule.' *Cheek* v *United States* (1991) 498 US 192.
[226] See Section 2 above. Section 2.02 of the MPC: '(c) Recklessly. A person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of

be held accountable. While Hoffmann would object, there are legitimate reasons for bringing such prosecutions of medical professionals who engage in criminal conduct recklessly or negligently.

Another question, as discussed in Chapter Three, would be whether medical professionals could reasonably rely on the legal opinions discussed in Chapter Two to excuse their liability, namely the legal opinion of the US Administration that denied that EITs constituted criminal or unlawful acts. In discussing criminal prosecutions of medical professionals for illegal drug distribution, Deborah Sprenger, practising lawyer, notes that 'courts have held that a deliberate course of conduct whereby the defendant avoids the requisite guilty knowledge may be held tantamount to guilty knowledge *per se*.'[227] 'In these cases, the trial court may issue to the jury a "conscious avoidance" charge, also known as a "wilful blindness" instruction.'[228] Hoffmann notes that while medical professionals may rely on the defence that they acted in good faith, courts have emphasised that 'the good faith test must be an objective, not a subjective test.'[229] She adds that 'such an objective test has allowed prosecutors to bring in evidence of "red flags," i.e., indications that a reasonable physician would have known that his prescribing was not for a legitimate medical purpose.'[230] Nonetheless, there is a significant difference between legitimate expectations, reasonable reliance and the so-called wilful blindness doctrine.[231] Indeed, legitimate expectation and reasonable reliance on the US Administration's legal opinions, if available, could excuse medical professionals from accountability for their involvement in the EITs. To the contrary, the wilful blindness doctrine that affirms the medical professional's

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the actor's conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a law-abiding person would observe in the actor's situation.
(d) Negligently. A person acts negligently with respect to a material element of an offense when he should be aware of a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that the actor's failure to perceive it, considering the nature and purpose of his conduct and the circumstances known to him, involves a gross deviation from the standard of care that a reasonable person would observe in the actor's situation.'

[227] Sprenger (n 191) 713, § 2[a].

[228] Diane E. Hoffmann, 'Treating Pain verses Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies' (2008) 1 *Saint Louis University Journal of Health Law and Policy* 231, 276.

[229] ibid 278. See: *US* v *Hurwitz* (2006) 459 F.3d, 480: 'Every court to examine the issue has held that the objective standard that the doctor acted in accordance with what he reasonably believed to be proper medical practice should apply.'

[230] Hoffmann (n 228) 278; John Tierney, 'Trafficker or Healer? And Who's the Victim?' *The New York Times* (27 March 2007) F1.

[231] *US* v *Katz* (2006) 445 F.3d 1023, 1031. See also: Justin C. From, 'Avoiding Not-So-Harmless Errors: The Appropriate Standards for Appellate Review of Wilful-Blindness Jury Instructions' (2011) 97 *Iowa Law Review* 275, 281.

knowledge of the criminality of the act would prevent them from relying on the legal opinions of the US Administration. Again, the presence or absence of knowledge is affected by the presence of legal advice from government advisors.

Given that involvement in EITs may fall within the scope of criminal negligence offences, criminal proceedings should be possible with regard to a wide range of criminal conduct perpetrated by medical professionals. Such prosecutions have not proven useful to date as all consecutive administrations have claimed that EITs were lawful and so did not trigger a criminal inquiry. However, other acts that go beyond mere EITs, for example, criminal disclosure of medical data, falsifying medical data etc., have not gained the same level of attention. Failure to consider these crimes may become less tenable in terms of growing evidence of what went on in detention centres. These crimes are worthy of further investigation, with a view to initiating criminal proceedings.

Lastly, the location of criminal conduct is not irrelevant. Where the involvement of medical professionals in EITs occurred within the territorial jurisdiction of the US, criminal prosecutions are possible. Indeed, the case law considered above was concerned with crimes committed by medical professionals within US territory. This raises the question of whether they could be prosecuted for the same criminal offences if they were perpetrated abroad. The issue of extraterritorial jurisdiction was discussed in the case of *RJR Nabisco, Inc.* v *The European Community*.[232] There, the court affirmed the presumption against extraterritorial jurisdiction unless US Congress decided otherwise. In the US, there are extraterritorial laws that cover offences taking place in planes or federal buildings internationally, sexual conduct with minors, conspiracy to commit a crime in the US, and also torture, among others.[233]

[232] *RJR Nabisco, Inc.* v *The European Community* (2016) 136 S.Ct. 2090.
[233] Charles Doyle, 'Extraterritorial Application of American Criminal Law' (2016) *Congressional Research Service* 94.

5.2. Using the Mechanism of Universal Jurisdiction

While there is a serious impediment to bringing criminal proceedings against the medical professionals in cases where acts occurred outside of the US, some possibility is offered by the principle of universal jurisdiction. This has been used to prosecute individuals who, for example, committed genocide, crimes against humanity or war crimes, regardless of their nationality or residence.[234] Similarly, the principle of universal jurisdiction could be used to prosecute the crime of torture.[235] Such prosecutions, which rely on the principle of universal jurisdiction, have been initiated in several countries around the world, including in the US.[236] The rationale behind the principle of universal jurisdiction is that some crimes, including torture, are of such gravity that they affect the international community as a whole and so cannot be left unaddressed.[237] The principle of universal jurisdiction could be used by states to prosecute medical professionals for torture, perpetrated anywhere in the world.

However, while US domestic courts have relied on the principle of universal jurisdiction to investigate and prosecute crimes perpetrated in different parts of the world, it is very unlikely that the principle will be used to prosecute medical professionals for their involvement in EITs in American detention centres. This is because the acts were authorised by the previous Administration, and despite significant evidence on the issue, the US Administration continues to claim that EITs were legal at the time. While the earlier section discusses the option of criminal prosecutions for a variety of criminal conduct, the principle of universal jurisdiction is limited to genocide, crimes against

[234] Cherif M. Bassiouni, 'The Institutionalisation of Torture under the Bush Administration' (2006) 37 *Case Western Reserve Journal of International Law* 389; Marjorie Cohn (eds.), *The United States and Torture: Interrogation, Incarceration, and Abuse* (New York University Press: New York, 2011) 13. See for example: REDRESS and FIDH, 'Strategies for the Effective Investigation and Prosecution of Serious International Crimes. The Practice of Specialised War Crime Units' (2010).
[235] Tom Malinowski, 'Banned State Department Practices', in Kenneth Roth, Minky Worden and Amy D. Bernstein (eds.), *Torture: Does It make Us Safe? Is It Ever OK? A Human Rights Perspective* (The New Press: New York, 2005)139–44.
[236] REDRESS and FIDH, 'Strategies for the Effective Investigation and Prosecution of Serious International Crimes. The Practice of Specialised War Crime Units' (2010).
[237] Bassiouni (n 234) 81.

humanity, war crimes and torture. As such, the chances of such proceedings being initiated are lower than in relation to the broader range of criminal conduct discussed in the section above.

6. Conclusion

This chapter has argued that there is a range of ways in which medical professionals might potentially be brought to account for their involvement in EITs, by way of disciplinary, civil and criminal avenues for legal recourse. As discussed above, several disciplinary complaints have been initiated, however, they have not resulted in official investigations and/or disciplinary steps being taken against the medical professionals involved. Among the variety of civil avenues, only one case under the Alien Tort Statute has proceeded even so far as to be settled out of court. No other civil claims have been successful. Similarly, despite a variety of criminal accountability options, no such proceedings have been progressed. However, this chapter has aimed to demonstrate that the fact that medical professionals have not been held accountable thus far is not due to the lack of adequate legal avenues available. Rather, it has shown the range of different options that have not been initiated to date and how they could address the lack of legal accountability of medical professionals for their involvement in the EITs.

While considering the severity of EITs that may amount to criminal conduct, criminal proceedings may appear to be the most appropriate recourse for justice, however, other legal avenues should not be neglected. Indeed, as is clear from *Salim* v *Mitchell*, detainees who were subjected to EITs, may be able to seek redress in the form of compensation for the pain or suffering experienced. The civil route does not address the issue that the medical professionals involved can continue to practice medicine and walk free, despite involvement in criminal offences, for which any ordinary citizen may face dire consequences. The successful engagement with the Alien Tort Statute in *Salim* v *Mitchell*, which provided the claimants with some compensation opens the doors for similar future proceedings. This follows the emergence of evidence in the SSCI report, partially made public. As the full SSCI report is yet to be disclosed, the evidence which may emerge in the future is likely to help with further

proceedings. Furthermore, the rebuttal of the US Administration's claims on the fiduciary relationship and the dual loyalties challenge means that there is a real purpose of taking the possibility of the other legal challenges seriously.

The question that follows is, what is the reason for the lack of accountability? As shown in this chapter, the law is not the problem and there are several avenues for legal recourse which could be used to bring medical professionals to justice. The issue goes back to the perception of EITs as legal. If EITs are legal, medical professionals could not face accountability for their involvement in their practice. Understandably, the legality of EITs has been challenged and does not stand up to legal scrutiny. However, even if EITs could be seen as legal *per se*, this thesis shows other criminal and unlawful conduct that medical professionals have been involved in and could face accountability for outside of the EIT legality debate, namely, acting in breach of fiduciary duties etc., in breach of confidentiality in medical data, falsifying medical data, withholding or withdrawing medical care, etc. As such, this thesis contributes to challenging impunity.

As this chapter has also shown, the existence of the fiduciary relationship plays an important role across the different avenues for legal recourse. In disciplinary proceedings, the breach of the fiduciary relationship provides a ground for disciplinary actions. Among civil routes, a breach of the fiduciary relationship is an action in its own right, but may also provide the basis for an action in malpractice. Among the criminal avenues for legal recourse, a breach of the fiduciary relationship provides a basis for criminal negligence claims. While some of these legal routes may be available even where there is no fiduciary relationship, because the fiduciary relationship prescribes a higher standard of conduct, relying on action based on a breach of the fiduciary relationship, may be beneficial.

CONCLUSION

This thesis has challenged the US Administration's arguments that facilitated the involvement of medical professionals in EITs in American detention centres, and served to block legal action against them. Namely, the US Administration argued, first, that medical professionals were not in a fiduciary relationship with detainees and, second, that even where a fiduciary relationship could be established, the medical professionals would owe military duties that would trump their medical duties. This thesis demonstrated that these arguments are fundamentally flawed, holding true only in exceptional cases. Indeed, it argued that the fiduciary relationship can be established by one or other means between medical professionals and detainees across the majority of the ten stages of involvement laid out in the taxonomy, described in Chapter One, and independent of the role undertaken by medical professionals (as BSCs or ordinary medical professionals). This thesis further challenged the argument that medical professionals would need to abandon their duties towards detainees as patients, in order to be able to discharge their duties towards the state. It thus sought to establish that the US Administration's arguments fail accurately to reflect existing US law.

Nonetheless, this thesis has shown that medical professionals continue to evade accountability. No medical professional has been prosecuted in domestic courts. Several complaints have been brought before state medical bodies; however, in each case they did not result in any disciplinary proceedings. Only one civil suit has progressed against two medical professionals and this was settled outside of court. Such a response to serious allegations of medical involvement in EITs raises serious concerns surrounding the issue of impunity for state authorised criminal or otherwise unlawful conduct. In this light, this thesis engaged with the available avenues for bringing medical professionals to account for their involvement in EITs. The taxonomy developed in Chapter One allowed a nuanced analysis of the range of conduct undertaken by doctors in detention centres, this was judged necessary in deciding upon which kind of legal action is most appropriate.

It was suggested that the fact that EITs are authorised by the state does not mean that medical professionals could not be held accountable for their involvement. The question should not be 'if' but 'when.' Indeed, a small step in this direction has been achieved by way of the civil suit brought under the Alien Tort Statute in *Salim* v *Mitchell.*[1] This followed the release of the Senate Select Committee on Intelligence report discussed in Chapter One. However, as discussed in Chapter Seven, there are other options for holding medical professionals to account, and especially, avenues for legal recourse for breach of the fiduciary relationship, using disciplinary, civil or criminal avenues. This thesis has argued that the concept of the fiduciary relationship can play an important role in this endeavour. This concluding section summarises the original contribution of this research and concludes with the implications of this research for policy and lawmakers.

Original Contribution of the Research

The taxonomy has allowed me to present a more nuanced analysis of how different kinds of conduct might be sanctioned, and particularly, by establishing the fiduciary relationship across the different stages and addressing the dual loyalties challenge. It provided the basis for a discussion where, among the ten stages of the taxonomy, the fiduciary relationship can be attached between medical professionals and detainees, differentiating between cases where the dual loyalties challenge occurs and where it does not. As a result, this thesis has been able to challenge the basis for the US Administration's attempt at the blanket exclusion of liability. This step included challenging the US Administration's arguments that medical professionals in American detention centres are not in a fiduciary relationship with detainees and even if they were, that duties to the state would trump their duties to the detainees. In so doing it has foregrounded the significance of the fiduciary relationship for future attempted litigation. This research adds to research on using the fiduciary relationship for litigation. Indeed, the most plausible option to address impunity for medical involvement in the EITs, it seems, is to strengthen the legal responses domestically, through engaging different routes to legal

[1] See Chapter Seven, Section 4.1.

recourse. Again, relying on the concept of fiduciary relationship can help to achieve this by equipping the detainees (as patients) with a stronger position before the law and opening additional avenues for legal recourse. As explained, this is because the special relationship between medical professionals and patients provides for the highest standard of conduct that can be imposed by law.[2] This thesis proposed that the fiduciary relationship can be used to strengthen the legal responses to the involvement of medical professionals in EITs.

As Chapter Five argues, it should not be accepted that a dual loyalties conflict is always and inevitably present, requiring medical professionals to abandon their medical duties. It is true that the fiduciary relationship between medical professionals and patients does not exist in a vacuum and is affected by other considerations. Medical professionals often have non-fiduciary duties towards others that may present as a dual loyalties conflict where medical professionals would be required to abandon their duties towards their patients. However, where military medical professionals are asked to be involved in criminal conduct, the dual loyalties conflict will not manifest as the duties owed as doctors will be aligned with those owed as soldiers: not to participate in such conduct. Where a dual loyalties conflict occurs, the existence of the fiduciary relationship can be used to guide the medical professionals in balancing the concurring duties they may have. In such a case, as Chapter Six argues, there are good reasons for recognising the fiduciary duties as trumping the non-fiduciary duties.

Medical professionals are significantly regulated in their dealings with patients. They are subject to civil and criminal laws, and disciplinary norms. Chapter Seven maps the most relevant avenues for legal recourse for holding medical professionals accountable for their involvement in EITs which constitute a violation of civil and criminal laws, and disciplinary norms. The concept of the fiduciary relationship plays a potentially important role within many of these avenues, but one which has hitherto been neglected. As explained in Chapter Three, over the years, several scholars, including

[2] Nicolas P. Terry, 'Physicians and Patients Who "Friend" and "Tweet" Constructing a Legal Framework for Social Networking in a Highly Regulated Domain' (2010) 43 Indiana Law Review 285, 304.

Tan and Ost[3] have argued for a greater reliance on the concept of the fiduciary relationship in bringing medical professionals to account, albeit in the vastly different context of sexual misconduct against patients. Ost, for example, notes that: '[a] doctor who proceeds to breach the sexual boundaries has not only violated the patient's trust, he has also failed to respect the mutuality of the doctor-patient relationship, treating the patient not as an autonomous partner but as a means to achieve his own self-interest.'[4] The existence of the fiduciary relationship makes a breach of the medical professionals' duties more severe and, as such, requires a comprehensive legal response. Indeed, this thesis argues that this is the very reason why legal action relying on the concept of the fiduciary relationship should play a role in bringing medical professionals to account for their involvement in EITs. As shown in this thesis, the existence of the fiduciary relationship means that the patient can benefit from additional legal avenues for legal recourse that are otherwise not available or are less likely to succeed. However, as identified in the thesis, these have not been used to date.

It should be noted that the US Administration's advice on the fiduciary relationship also has a potentially broader application, strengthening the case for resisting it. It could potentially be replicated in any other context where national safety or security is engaged, thus undermining the concept of the fiduciary relationship to the considerable detriment of both patients and medical professionals.

Finally, the research makes a significant and original contribution to understanding the legal implications of the complex role played by medical professionals in EITs in American detention centres. Specifically, it explained the role of medical professionals in EITs and the justification of their use, and challenged the two arguments that enabled medical involvement in EITs to enable bringing medical professionals to account. However, there is a limitation to its application. This thesis focuses specifically on medical professionals in American detention centres who were involved in

[3] David Tan, 'Sexual Misconduct by Doctors and the Intervention of Equity' (1997) 4 African Journal of Laboratory Medicine 243; Suzanne Ost, 'Breaching the Sexual Boundaries in the Doctor-Patient Relationship: Should English Law Recognise Fiduciary Duties?' (2016) 24 Medical Law Review 2.
[4] Ost (n 3) 206.

EITs as part of the War on Terror. The situation of medical professionals in other circumstances (or other countries), and the way they are entangled in the process of criminal conduct, would differ.[5] This could be a fruitful additional pathway to further research on other cases.

Implications of the Research

The legal analysis in this thesis is unlikely to translate into action until there is greater political will in favour of doing so. Indeed, in the current political climate, it is very unlikely that the issue of impunity will be addressed. This scepticism is substantiated by the fact that the Trump Administration has been very hostile to any attempt at investigating US involvement in torture and other crimes in Afghanistan by the International Criminal Court.[6] Conversely, these arguments could assist civil society in exploring different options for legal recourse that go beyond the current focus on torture.

Nonetheless, this research has important implications for law and policymakers. It shows the challenges faced by medical professionals when engaging with the military that need to be addressed to protect patients (detainees) from ill-treatment but also to protect medical professionals from becoming involved in criminal and unlawful acts. The research has important implications for state medical boards who have hitherto shied away from ensuring the medical professionals' accountability for their involvement in EITs. The research raises important questions for how to provide comprehensive protection for the doctor-patient fiduciary relationship that, despite being recognised as *quasi sacrosanct*, continues to be subjected to attacks that undermine or weaken its status.

This work to strengthen the protection of the doctor-patient fiduciary relationship requires the combined efforts of different actors, including lawmakers, courts, practising lawyers, and state medical boards. The law on the fiduciary relationship, discussed in Chapter Three should provide adequate protections to patients, but should also protect the doctor-patient relationship from excessive

[5] Steven H. Miles, 'The Doctors who Torture Accountability Project.' Available at: http://www.doctorswhotorture.com/. See also: Steven H. Miles, 'The New Accountability for Doctors who Torture' (2014) *Health and Human Rights Journal*.
[6] Daphne Psaledakis and Michelle Nichols, 'US Blacklists ICC Prosecutor over Afghanistan War Crimes Probe' *Reuters* (2 September 2020).

interference. However, as Chapter Three also shows, the Instruction does not fully reflect the current law and gives the impression that the law on the fiduciary relationship is narrower, especially where it denies that a fiduciary relationship could be imposed in certain circumstances. The Instruction cannot change the law. However, the Instruction, together with the 'War on Terror' narrative denied detainees of the protections that would otherwise have attached to their relationships with medical professionals. If the laws are adequate and the issue is with their implementation, another question that needs to be asked is how to ensure that the laws are fully enforced. As such, the US Administration must produce advice that accurately reflects the law. If there is a role for law-makers, it might be one of legislating to remove any ambiguity that the US Administration remains able to exploit in its guidance.

Finally, state medical bodies must play a pro-active role in responding to allegations of medical involvement in criminal and unlawful acts, and by doing so, fulfil their duty to protect the public. As Annas notes, 'restricting physicians who have engaged in crimes against humanity from practising medicine is done not to punish them, but to protect the public and the medical profession.'[7] He suggests that:

> When that trust is betrayed and physicians use their skills to harm at the direction of the state, it is a matter of protecting the integrity of the medical profession, as well as a form of self-defence for potential patients, that their privilege to practise a healing profession be revoked or restricted.[8]

State medical bodies should act even where the criminal or unlawful conduct is authorised by the state. Indeed, they can and should play an important safeguarding role in such cases. As such, if all of the above-identified actors were to play their role, it would be possible to address the impunity medical professionals currently enjoy and provide detainees with some justice.

[7] George J. Annas, 'Medical Ethics and Human Rights in Wartime' (2015) 105 South African Medical Journal 240.
[8] ibid.

Bibliography

Books

Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Springer: Dordrecht, 2008)

Andrew Ashworth, *Principles of Criminal Law* (Oxford University Press: New York, 2006)

Ilias Bantekas and Susan Nash, *International Criminal Law* (Routledge-Cavendish: Oxford, 2007)

Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics*. *Volume 1* (Office of the Surgeon General: Falls Church, 2003)

Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (Oxford University Press: New York, 2001)

Gregg M. Bloche, *The Hippocratic Myth. Why Doctors Are Under Pressure to Ration Care, Practice Politics, and Compromise Their Promise to Heal* (Palgrave Macmillan: New York, 2011)

British Medical Association, *BMA Medical Ethics Today: Its Practice and Philosophy* (BMJ Publishing Group: London, 1993)

British Medical Association, *Medicine Betrayed* (Zed Books: London, 1992)

British Medical Association, *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses* (Zed Books: London, 1998)

Howard Brody, *The Healer's Power* (Yale University Press: New Haven, 1992)

Harold H. Bruff, *Bad Advice: Bush's Lawyers in the War on Terror* (University Press of Kansas: Lawrence, 2009)

Erik Castren, *The Present Law of War and Neutrality* (Annales Academiae Scientiarum Fennicae: Helsinki, 1954)

Dick Cheney, Richard B. Cheney and Liz Cheney, *In My Time: A Personal and Political Memoir* (Threshold Editions: New York, 2011)

Andrew Clapham, Paola Gaeta, Marco Sassòli, Iris van der Heijden (eds.), *The 1949 Geneva Conventions: A Commentary* (Oxford University Press: Oxford, 2015)

David Cole, *The Torture Memos: Rationalising the Unthinkable* (The New Press: New York, 2009)

Marjorie Cohn (eds.), *The United States and Torture: Interrogation, Incarceration, and Abuse* (New York University Press: New York, 2011)

Edward M. Dangel, *Criminal Law* (Edan Publications: Boston MA, 1951)

Joan Dassin, *Torture in Brazil: A Shocking Report on the Pervasive Use of Torture by Brazilian Military Governments, 1964-1979* (University of Texas Press: Austin TX, 1998)

Mark Denbeaux and Jonathan Hafetz, *The Guantanamo Lawyers. Inside a Prison Outside the Law* (New York University Press: New York, 2009)

Alan M. Dershowitz, *Why Terrorism Works: Understanding the Threat, Responding to the Challenge* (Yale University Press: New Haven, 2002)

Yoram Dinstein, *The Defence of 'Obedience to Superior Orders' in International Law* (Oxford University Press: Oxford, 2012)

Dan B. Dobbs, *The Law of Torts* (West Academic Publishing: St. Paul, MN, 2000)

Joshua Dressler, *Understanding Criminal Law* (Carolina Academic Press: Durham NC, 2018)

Douglas Ezzy, *Qualitative Analysis: Practice and Innovation* (Allen & Unwin: Crows Nest NSW, 2002)

Paul D. Finn, *Fiduciary Obligations* (Law Book Co.: Sydney, 1977)

David P. Forsythe, *The Politics of Prisoner Abuse: The United States and Enemy Prisoners after 9/11* (Cambridge University Press: New York, 2011)

Bryan A. Garner (ed.), *Black's Law Dictionary* (West Publishing Group: St. Paul MN, 2004)

Yuval Ginbar, *Why Not Torture Terrorists? Moral, Practical and Legal Aspects of the 'Ticking Bomb' Justification for Torture* (Oxford University Press: Oxford, 2008)

John C.P. Goldberg and Benjamin C. Zipursky, *The Oxford Introductions to US Law: Torts* (Oxford University Press: Oxford, 2010)

Ryan Goodman and Mindy J. Roseman (eds.), *Interrogations, Forced Feedings, and the Role of Health Professionals: New Perspectives on International Human Rights, Humanitarian Law, and Ethics* (Harvard University Press: Cambridge MA, 2009)

Rebecca Gordon, *Mainstreaming Torture: Ethical Approaches in the Post-9/11 United States* (Oxford University Press: Oxford, 2014)

Karen J. Greenberg, *The Torture Debate in America* (Cambridge University Press: Cambridge, 2006)

Michael L. Gross, *Bioethics and Armed Conflicts. Moral Dilemmas of Medicine and War* (The MIT Press: London, 2003)

Mark A. Hall, Mary A. Bobinski and David Orentlicher, *Medical Liability and Treatment Relationships* (Aspen Publishers: New York, 2008)

Herbert L.A. Hart, *Punishment and Responsibility* (Oxford University Press: New York, 2008)

David Hayton, Paul Matthews and Charles Mitchell, *Underhill and Hayton Law of Trusts and Trustees* (Butterworths Law, 2010)

Samuel P. Huntington, *The Soldier and the State: The Theory and Politics of Civil-Military Relations*. (Belknap Press of Harvard University Press: Cambridge MA, 1957)

Terry Hutchinson, *Researching and Writing in Law* (Reuters Thomson, 2010)

Joseph B. Keenan and Brendan F. Brown, *Crimes Against International Law* (Public Affairs Press: Washington, DC, 1950)

Hans Kelsen, *Peace Through Law* (University of North Carolina Press: Chapel Hill, 1944)

Wayne LaFave, *Substantive Criminal Law* (West's Criminal Practice Series, 2003)

Paul Lauritzen, *The Ethics of Interrogation: Professional Responsibility in an Age of Terror* (Georgetown University Press: Washington DC, 2013)

Hersch Lauterpacht and Lassa Oppenheim, *International Law: A Treatise. Vol. II. Disputes, War, and Neutrality* (Longmans, Green, and Co.: New York, 1952)

Robert J. Lifton, *The Nazi Doctors. Medical Killing and the Psychology of Genocide* (Basic Books, 2000)

Bernard Lo and Marilyn J. Field (eds.), *Conflict of Interest in Medical Research, Education, and Practice* (The National Academies Press: Washington DC, 2009)

David W. Louisell and Harold Williams, *Medical Malpractice. Volume 1* (Matthew Bender, 1970)

David Luban, *Torture, Power and Law* (Cambridge University Press: Cambridge, 2014)

Frederick H. Maugham, *United Nations Organisations and the War Crimes* (Greenwood Press: Westport, Conn, 1951)

Steven H. Miles, *Oath Betrayed: America's Torture Doctors* (University of California Press: Berkeley, 2009)

Steven H. Miles, *Oath Betrayed, Torture, Medical Complicity, and the War on Terror* (Random House: New York, 2006)

Steven H. Miles, *Torture Doctors: Human Rights Crimes and the Road to Justice* (Georgetown University Press: Washington DC, 2020)

Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* (Brill Nijhoff: Leiden, 2014)

National Commission on Disappeared People, *Nunca Más: The Report of the Argentine National Commission on the Disappeared* (Farrar Straus Giroux/Index on Censorship: New York, 1986)

Mark J. Osiel, *Making Sense of Mass Atrocity* (Cambridge University Press: New York, 2009)

Mark J. Osiel, *Obeying Orders: Atrocity, Military Discipline and Law of War* (Transaction Publishers: New Brunswick, 1999)/Mark J. Osiel, *Obeying Orders* (Transaction Publishers: New Jersey, 2002)

Mark J. Osiel, *The End of Reciprocity: Terror, Torture, and the Law of War* (Cambridge University Press: Cambridge, 2009)

Jordan J. Paust, *Beyond the Law: The Bush Administration's Unlawful Responses in the "War" on Terror* (Cambridge University Press: Cambridge, 2007)

Michael Peel and Vincent Iacopino, *The Medical Documentation of Torture* (Cambridge University Press: Cambridge, 2002)

Jean S. Pictet (ed.), *IV The Geneva Convention of 12 August 1949: Commentary* (International Committee of the Red Cross: Geneva, 1952)

William L. Prosser, *Handbook of the Law of Torts* (West Publishing Company: St. Paul MN, 1971)

Steven R. Ratner, Jason S. Abrams, James L. Bischoff, *Accountability for Human Rights Atrocities in International Law. Beyond the Nuremberg Legacy* (Oxford University Press: New York, 2010)

Darius Rejali, *Torture and Democracy* (Princeton University Press: Princeton, 2009)

Marc Rodwin, *Medicine, Money and Morals: Physician's Conflict of Interest* (Oxford University Press: New York, 1993)

Erik Saar and Viveca Novak, *Inside the Wire: A Military Intelligence Soldier's Eyewitness Account of Life at Guantanamo* (Penguin Press: New York, 2005)

Yves Sandoz, Christophe Swinarski and Bruno Zimmermann, *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949* (International Committee of the Red Cross: Geneva, 1987)

Eric Stover and Elena O. Nightingale (eds.), *The Breaking of Bodies and Minds* (W.H. Freeman and Co.: New York, 1985)

Tomas S. Szasz, *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (Collier Books: New York, 1971)

Neil E. Weisfeld, Victoria D. Weisfeld, and Catharyn T. Liverman, *Military Medical Ethics: Issues Regarding Dual Loyalties. Workshop Summary* (National Academies Press: Washington DC, 2009)

Bradley W. Wendel, *Lawyers and Fidelity to Law* (Princeton University Press: Princeton, 2010)

Jeremy J. Wisnewski, *Understanding Torture* (Edinburgh University Press: Edinburgh, 2010)

Chapters in books

George J. Annas, 'The Legacy of the Nuremberg Doctors' Trial to American Bioethics and Human Rights' in Sheldon Rubenfeld (ed.), *Medicine after the Holocaust* (Palgrave Macmillan: New York, 2010)

Ruth Blakeley and Sam W. Raphael, 'Governing Human Rights: Rendition, Secret Detention and Torture in the War on Terror' in Sophie Harman and David Williams (eds.), *Governing the World? The Practice of Global Governance* (Routledge: London, 2013)

Richard B. Bilder and Detlev F. Vagts, 'Speaking Law to Power: Lawyers and Torture' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006)

Lee A. Casey and David B. Rivkin, Jr., 'Rethinking the Geneva Conventions' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006)

Marjorie Cohn, 'An American Policy of Torture' in Marjorie Cohn (ed.), *The United States and Torture: Interrogation, Incarceration, and Abuse* (New York University Press: New York, 2011)

Nathalie De Fabrique, 'Medical Malpractice' in Jeffrey S. Kreutzer, John DeLuca, and Bruce Caplan (eds.), *Encyclopedia of Clinical Neuropsychology* (Springer: New York, 2011)

Henry Donnedieu de Vabres, 'The Nuremberg Trial and the Modern Principles of International Criminal Law' in Guenael Mettraux (ed.), *Perspectives on the Nuremberg Trial* (Oxford University Press: New York, 2010)

Joshua Dratel and Stephen Gillers, 'Torture: The Road to Abu Ghraib and Beyond' in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006)

Anthony Duggan, 'Contracts, Fiduciaries, and the Primacy of the Deal' in Elise Bant and Matthew Harding (eds.), *Exploring Private Law* (Cambridge University Press: Cambridge, 2010)

Paul D. Finn, 'The Fiduciary Principle' in Timothy G. Youdan (ed.), *Equity, Fiduciaries and Trusts* (Carswell: Toronto, 1989)

Lora Flattum Hamp, ‘Analysis of Elder Abuse and Neglect Definitions Under State Law’ in Richard J. Bonnie, Robert B. Wallace, *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America* (National Academies Press: Washington DC, 2003)

Oren Gross, ‘The Prohibition on Torture and the Limits of the Law’ in Sanford Levinson (ed.), *Torture: A Collection* (Oxford University Press: Oxford, 2004)

Cecil Helman, ‘Introduction: The Healing Bond’ in Cecil Helman (ed.) *Doctors and patients. An Anthology* (Radcliffe Medical Press: Abingdon, 2003)

Edmund G. Howe, ‘Mixed Agency in Military Medicine: Ethical Roles in Conflict’ in Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003)

Edmund G. Howe, ‘New Biological Advances and Military Medical Ethics’ in Robert Armstrong, Mark Drapeau, Cheryl Loeb et al. (eds.), *Bio-Inspired Innovation and National Security* (National Defence University: Washington DC, 2010)

Edmund G. Howe, ‘Point/Counterpoint--A response to Drs Sidel and Levy (Physician-Soldier: A Moral Dilemma)’ in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003)

Robert A. Kutcher, ‘Breach of Fiduciary Duties’ in Ann E. Georgehead, Robert Y. Gwin and David A. Soley (eds.), *Business Torts Litigation* (American Bar Association: Chicago, 2005)

Christopher Kutz, ‘The Lawyers Know Sin: Complicity in Torture’ in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006)

Christopher Kutz, ‘The Philosophical Foundations of Complicity Law’ in John Deigh and David Dolinko (eds), *The Oxford Handbook of Philosophy of Criminal Law* (Oxford University Press: Oxford, 2011)

Chiara Lepora and Joseph Millum, ‘Individual Complicity: The Tortured Patient’ in Chiara Lepora and Robert E. Goodin (eds.), *On Complicity and Compromise* (Oxford University Press: Oxford, 2013)

David Luban, ‘Liberalism, Torture, and the Ticking Bomb’ in Karen J. Greenberg (ed.), *Torture Debate in America* (Cambridge University Press: Cambridge, 2006)

David Luban, ‘The Legacies of Nuremberg’ in Guenael Mettraux (ed.), *Perspectives on the Nuremberg Trial* (Oxford University Press: New York, 2010)

William Madden and Brian S. Carter, ‘Physician-Soldier: A Moral Position’ in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003)

Tom Malinowski, ‘Banned State Department Practices’, in Kenneth Roth, Minky Worden and Amy D. Bernstein (eds.), *Torture: Does It Make Us Safe? Is It Ever OK? A Human Rights Perspective* (The New Press: New York, 2005)

Donald J. Meyer, Robert I. Simon, and Daniel W. Shuman, ‘Professional Liability in Psychiatric Practice and the Requisite Standard of Care’ in Robert I. Simon and Liza H. Gold (eds.), *Textbook of Forensic Psychiatry* (American Psychiatric Publishing: Washington DC, 2010)

Paul B. Miller, ‘The Fiduciary Relationship’ in Andrew S. Gold and Paul B. Miller, *Philosophical Foundations of Fiduciary Law* (Oxford University Press: Oxford, 2014)

Seumas Miller and Michael J. Selgelid, ‘Ethics and the dual-use dilemma in the life sciences’ in Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Springer: Dordrecht, 2008)

Patricia Peppin, ‘A Feminist Challenge to Tort Law’ in Anne Bottomley (ed.), *Feminist Perspectives on the Foundational Subjects of Law* (Routledge Cavendish: London, 1996)

Dominic Rascona, ‘The Moral Obligation of United States Military Medical Service’ in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003)

Jean-Pierre Restellini and Romeo Restellini, ‘Prison-Specific Ethical and Clinical Problems’ in Stefan Enggist, Lars Møller, Gauden Galea and Caroline Udesen (eds.), *Prisons and Health* (World Health Organization: Copenhagen, 2014)

Victor W. Sidel and Barry S. Levy, ‘Physician-Soldier: A Moral Dilemma’ in Thomas E. Beam and Linette R. Sparacino (eds.), *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003)

Stephen Soldz, ‘Psychologists Defying Torture. The Challenge and the Path Ahead’ in Adrienne Harris and Steven Botticelli (eds.), *First do no Harm: The Paradoxical Encounters of Psychoanalysis, Warmaking, and Resistance* (Routledge: New York, 2010)

James G. Stewart, ‘Complicity’ in Markus Dubber and Tatjana Hörnle (eds), *Oxford Criminal Law Handbook* (Oxford University Press: Oxford, 2014)

Telford Taylor, ‘The Nuremberg Trials’ in Guenael Mettraux (ed.) *Perspectives on the Nuremberg Trial Perspectives on the Nuremberg Trial* (Oxford University Press: New York, 2010)

Sandra L. Visser, ‘The soldier and autonomy’ in Thomas E. Beam and Linette R. Sparacino (eds.) *Military Medical Ethics. Volume 1* (Office of the Surgeon General: Falls Church, 2003)

Richard H. Weisberg, ‘Loose Professionalism, or Why Lawyers Take the Lead on Torture’ in Sanford Levinson (ed.), *Torture: A Collection* (Oxford University Press: Oxford, 2004)

Journals

Fritz Allhoff, ‘Physician Involvement in Hostile Interrogations’ (2006) 15 *Cambridge Quarterly of Healthcare Ethics* 392

Jose E. Alvarez, ‘Torturing the Law’ (2006) 37 *Case Western Reserve Journal of International Law* 175

Erich D. Andersen, ‘Enhancement for Abuse of a Position of Trust under the Federal Sentencing Guidelines’ (1991) 70 *Oregon Law Review* 181

Marcia Angell, ‘Medicine: The Endangered Patient-Cantered Ethic’ (1987) 17 *The Hastings Centre Report* 12

George J. Annas, ‘American Vertigo: ‘Dual Use,’ Prison Physicians, Research, and Guantanamo’ (2011) 43 *Case Western Reserve Journal of International Law* 631

George J. Annas, 'Medical Ethics and Human Rights in Wartime' (2015) 105 *South African Medical Journal* 240

George J. Annas, **'**Medicine**,** Death and the Criminal Law' (1995) 333 *New England Journal of Medicine* 527

George J. Annas, 'Military Medical Ethics - Physician First, Last, Always' (2008) 359 *New England Journal of Medicine* 1087

George J. Annas, 'Unspeakably Cruel - Torture, Medical Ethics, and the Law' (2005) 20 *New England Journal of Medicine* 2127

George J. Annas, Sandra S. Crosby and Leonard H. Glantz, 'Guantanamo Bay: A Medical Ethics-free Zone?' (2013) 369 *New England Journal of Medicine* 101

Lydia Ansermet, 'Manifest Illegality and the ICC Superior Orders Defense' (2014) 47 *Vanderbilt Journal of Transnational Law* 1425

Nancy V. Baker, 'The Law: Who Was John Yoo's Client? The Torture Memos and Professional Misconduct' (2010) 40 *Presidential Studies Quarterly* 750

Roozbeh Baker, 'Customary International Law in the 21st Century: Old Challenges and New Debates' (2010) 21 *The European Journal of International Law* 190

Amrit K. Bal and B. Sonny Bal, 'Medicolegal Sidebar: State Medical Boards and Physician Disciplinary Actions' (2014) 472 *Clinical Orthopaedics and Related Research* 28

B. Sonny Bal, 'An Introduction to Medical Malpractice in the United States' (2009) 467 *Clinical Orthopaedics and Related Research* 339

Myles Balfe, 'Why Did US Healthcare Professionals Become Involved in Torture During the War on Terror?' (2016) 13 *Journal of Bioethical Inquiry* 449

Ilias Bantekas, 'The Contemporary Law of Superior Responsibility' (1999) 93 *American Journal of International Law* 573

Daphne Barak-Erez, 'The Doctrine of Legitimate Expectations and the Distinction between the Reliance and Expectation Interests' (2005) 11 *European Public Law* 584

Jeffrey A. Barker, 'Professional-Client Sex: Is Criminal Liability an Appropriate Means of Enforcing Professional Responsibility?' (1993) 40 *UCLA Law Review* 1289

T.B. Barlow, 'Medical Negligence Resulting in Death' (1948) 11 *Journal of Contemporary Roman-Dutch Law* 173

Michael C. Barnes and Stacey L. Sklaver, 'Active Verification and Vigilance: A Method to Avoid Civil and Criminal Liability when Prescribing Controlled Substances' (2013) 15 *DePaul Journal of Health Care Law* 93

Peter Bartlett, 'Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship' (1997) 5 *Medical Law Review* 193

Cherif M. Bassiouni, 'The Institutionalisation of Torture under the Bush Administration' (2006) 37 *Case Western Reserve Journal of International Law* 389

Cherif M. Bassiouni, 'Universal Jurisdiction for International Crimes: Historical Perspectives and Contemporary Practice' (2001) 42 *Virginia Journal of International Law* 81

Ronald Bayer, ‘Public Health Policy and the AIDS Epidemic. An End to HIV Exceptionalism?’ (1991) 324 *New England Journal of Medicine* 1500

Alex J. Bellamy, ‘No Pain, No Gain? Torture and Ethics in the War on Terror’ (2006) 82 *International Affairs* 121

Solomon R. Benatar, ‘Facing Ethical Challenges in Rolling-out Antiretroviral Treatment in Resource-poor Settings’ (2006) 15 *Cambridge Quarterly Health Ethics* 322

Solomon R. Benatar and Ross E.G. Upshur, ‘Dual Loyalties of Physicians in the Military and Civilian Life’ (2008) 12 *Public Health and the Military* 2161

Leonard Berlin, ‘Consequences of Being Accused of Malpractice’ (1997) 169 *Journal of Roentgenology* 1219

Leonard Berlin, ‘Malpractice Issues in Radiology: *Res Ipsa Loquitur*’ (2009) 193 *American Journal of Roentgenology* 1475

Peter Birks, ‘The Content of Fiduciary Relationship’ (2000) 34 *Israel Law Review* 19

Ruth Blakeley and Sam Raphael, ‘Human Rights Fact-finding and the CIA’s Rendition, Detention and Interrogation Programme: A Response to Cordell’ (2017) 21 *International Area Studies Review* 169

Gregg M. Bloche, ‘Clinical Loyalties and the Social Purposes of Medicine’ (1999) 281 *Journal of the American Medical Association* 268

Gregg M. Bloche and Jonathan H. Marks, ‘Doctors and Interrogators at Guantanamo Bay’ (2005) 352 *The New England Journal of Medicine* 6

Gregg M. Bloche and Jonathan H. Marks, ‘When Doctors Go to War’ (2005) 352 *The New England Journal of Medicine* 3

Dayna Bowen Matthew, ‘Implementing American Health Care Reform: The Fiduciary Imperative’ (2011) 59 *Buffalo Law Review* 715

Daniele Bryden and Ian Storey, ‘Duty of Care and Medical Negligence’ (2011) 11 *Continuing Education in Anaesthesia* 124

Isaac D. Buck, ‘Overtreatment and Informed Consent: A Fraud-Based Solution to Unwanted and Unnecessary Care’ (2016) 43 *Florida University Law Review* 902

Stephen C. Bush, ‘Formation of the Physician-Patient Relationship: The Oregon Court of Appeals Clarifies, but Questions Remain.’ (2010) 13 *Physician Organizations* 11

Michael Cahill and Peter Jacobson, ‘Applying Fiduciary Responsibilities in the Managed Care Context’ (2000) 26 *American Journal of Law and Medicine* 155

Angela Campbell and Kathleen Cranley Glass, ‘The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research’ (2001) 46 *McGill Law Journal* 473

Drew Carlson and James N. Thompson, ‘The Role of State Medical Boards’ (2005) 7 *Virtual Mentor* 311

Peter Cashman, ‘Medical Benefits Fraud: Prosecution and Sentencing of Doctors, Part 1’ (1982) 7 *Legal Services Bulletin* 58

Diana Chapman Walsh, 'Divided Loyalties in Medicine: The Ambivalence of Occupational Medical Practice' (1986) 23 *Social Science and Medicine* 789

Fred Charatan, 'Brazil Challenges Doctors Accused of Torture' (1999) 318 *British Medical Journal* 757

James F. Childress, Ruth R. Faden, Ruth D. Gaare, *et al*., 'Public Health Ethics: Mapping the Terrain' (2002) 30 *Journal of Law, Medicine and Ethics* 170

Michele Chwastiak, 'Torture as Normal Work: The Bush Administration, the Central Intelligence Agency and "Enhanced Interrogation Techniques"' (2015) 22 *Organization: The Critical Journal of Organization, Theory and Society* 4

John C. Coffee, Jr., 'From Tort to Crime: Some Reflections on the Criminalisation of Fiduciary Breaches and the Problematic Line Between Law and Ethics' (1981) 19 *American Criminal Law Review* 117

Fred Cohen, 'No Medical Records Privacy for an Inmate in Sexual Predator Commitment Proceeding' (2010) 22 *Correctional Law Reporter* 35

Phyllis Coleman, 'Sex Between Psychiatrist and Former Patient.: A Proposal for a "No Harm, No Foul" Rule' (1988) 41 *Oklahoma Law Review* 23

Roger Collier, 'Irreconcilable Choices in Military Medicine' (2010) 182 *Canadian Medical Association Journal* E821

Norman Daniels and James Sabin, 'Limits to Health Care: Fair Procedures, Democratic Deliberation and the Legitimacy Problem for Insurers' (1997) 26 *Philos Public Affairs* 303

Deborah A. DeMott, 'Beyond Metaphor: An Analysis of Fiduciary Obligation' (1988) *Duke Law Journal* 879

Kelly K. Dineen and James M. DuBois, 'Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?' (2016) 42 *American Journal of Law and Medicine* 7

James Edelman, 'When Do Fiduciary Duties Arise?' (2010) 126 *Law Quarterly Review* 302

Ronald L. Eisenberg and Leonard Berlin, 'Malpractice Issues in Radiology: When Does Malpractice Become Manslaughter?' (2002) 179 *American Journal for Roentgenology* 331

Ole Espersen, 'Statutes of the International Tribunal for Investigation of Torture' (1991) 17 *Journal of Medical Ethics* 64

Mark G. Field, 'Structured Strain in the Role of the Soviet Physicians' (1953) 58 *American Journal of Sociology* 493

Robert I. Field, 'Why is Health Care Regulation So Complicated?' (2008) 33 *Pharmacy and Therapeutics* 607

James A. Filkins, '"With No Evil Intent": The Criminal Prosecution of Physicians for Medical Negligence' (2001) 22 *Journal of Legal Medicine* 471

Claire O. Finkelstein and Michael Lewis, 'Should Bush Administration Lawyers Be Prosecuted for Authorising Torture?' (2010) *University of Pennsylvania Law Review* 223

Paul Finn, 'Fiduciary Reflections' (2014) 88 *Australian Law Journal* 127

Caroline Forell and Anna Sortun, 'The Tort of Betrayal of Trust' (2009) 42 *Michigan Journal of Law Reform* 557

Jonathan J. Frankel, 'Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures' (1994) 103 *Yale Law Journal* 1297

Tamar Frankel, 'Fiduciary Law' (1983) 71 *California law Review* 795

Justin C. From, 'Avoiding Not-So-Harmless Errors: The Appropriate Standards for Appellate Review of Wilful-Blindness Jury Instructions' (2011) 97 *Iowa Law Review* 275

Lon L. Fuller and William R. Perdue 'The Reliance Interest in Contract Damages' (1936) 46 *Yale Law Journal* 373

Barry Gewen, 'The Gray Zone: Defining Torture' (2010) 173 *World Affairs* 49

Gregg J. Gittler and Ellie J. Goldstein, 'The Elements of Medical Malpractice: An Overview' (1996) 23 *Clinical Infectious Diseases* 1152

Shimon M. Glick, 'Unlimited Human Autonomy - A Cultural Bias?' (1997) 336 *New England Journal of Medicine* 954

Brian Goldman, 'Chilean Medical College Battling Doctor Participation in Torture' (1985) 15 *Canadian Medical Association Journal* 1414-6

Melissa M. Goldstein, 'Health Information Privacy and Health Information Technology in the US Correctional Setting' (2014) 104 *American Public Health Association* 803

Steven Greer, 'Is the Prohibition against Torture, Cruel, Inhuman and Degrading Treatment Really "Absolute" in International Human Rights Law?' (2015) 15 *Human Rights Law Review* 101

Michael A. Grodin and George J. Annas, 'Legacies of Nuremberg Medical Ethics and Human Rights' (1996) 276 *Journal of the American Medical Association* 1682

Michael A. Grodin and George J. Annas, 'Physicians and Torture: Lessons from the Nazi Doctors' (2007) 89 *International Review of the Red Cross Journal* 635

Michael A. Grodin, George J. Annas and Leonard H. Glantz, 'Medicine and Human Rights: A Proposal for International Action' (1993) 23 *Hastings Centre Report* 8, 11

Michael L. Gross, 'Bioethics and Armed Conflicts. Mapping the Moral Dilemmas of Medicine and War' (2004) 6 *Hasting Centre Report* 29

Michael L. Gross, 'Doctors in the Decent Society: Medical Care, Torture and Ill-Treatment' (2004) 18 *Bioethics* 181

Michael L. Gross, 'Force-Feeding, Autonomy, and the Public Interest' (2013) 369 *New England Journal of Medicine* 103

Oren Gross, 'Are Torture Warrants Warranted? Pragmatic Absolutism and Official Disobedience' (2004) 88 *Minnesota Law Review* 1481

Oren Gross, 'The Grave Breaches System and the Armed Conflict in the Former Yugoslavia' (1995) 16 *Michigan Journal of International Law* 801

E. Haavi Morreim, 'Medicine Meets Resource Limits: Restructuring the Legal Standard of Care' (1997) 59 *University of Pittsburgh Law Review* 71

Abraham Halpern, John Halpern and Sean Doherty, 'Enhanced Interrogation of Detainees: Do Psychologists and Psychiatrists Participate?' (2008) 3 *Philosophy, Ethics, and Humanities in Medicine* 21

Thomas L. Hafemeister and Richard M. Gulbrandsen, 'The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that Are Not Medically Indicated' (2009) 39 *Seton Hall Law Review* 335

Thomas L. Hafemeister and Sarah Payne Bryan, 'Beware Those Bearing Gifts: Physicians' Fiduciary Duty to Avoid Pharmaceutical Marketing' (2009) 57 *University of Kansas Law Review* 491

Thomas L. Hafemeister and Selina Spinos, 'Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient' (2009) 86 *Washington University Law Review* 1167

Lisa Hajjar, 'Does Torture Work? A Sociolegal Assessment of the Practice in Historical and Global Perspective' (2009) 5 *Annual Review of Law and Social Science* 311

Matthew Harding, 'Trust and Fiduciary Law' (2013) 33 *Oxford Journal of Legal Studies* 81

Emma Harries, 'The CIA and Enhanced Interrogation Techniques in the War on Terror' (2017) 33 *Intelligence and National Security* 1

Marie-Care Harris, 'Doctors Implicated in Tutsi Genocide' (1996) 347 *The Lancet* 684

Diane E. Hoffmann, 'Physicians Who Break the Law' (2009) 53 *Saint Louis University Law Journal* 1049

Diane E. Hoffmann, 'Treating Pain versus Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies' (2008) 1 *Saint Louis University Journal of Health Law and Policy* 231

Steven J. Hoffman, 'Ending Medical Complicity in State-Sponsored Torture' (2011) 378 *The Lancet* 1535

Gregory Hooks and Clayton Mosher, 'Outrages Against Personal Dignity: Rationalizing Abuse and Torture in the War on Terror' (2005) 83 *Social Forces* 1627

Edmund G. Howe, 'Ethical Issues Regarding Mixed Agency of Military Physicians' (1986) 23 *Social Science and Medicine* 803

Edmund G. Howe, 'Dilemmas in Military Medical Ethics Since 9/11' (2003) 3 *Kennedy Institute of Ethics Journal* 175

Edwin C. Hui, 'The Patient-Surgeon Relationship. Part II: Medical Fidelity as Morality and Law' (2005) 17 *Asian Journal of Oral and Maxillofacial Surgery* 210

Terry Hutchinson and Nigel Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research' (2012) 17 *Deakin Law Review* 83

Vincent Iacopino, Scott A. Allen and Allen S. Keller, 'Bad Science Used to Support Torture and Human Experimentation' (2011) 331 *New Series* 34

Vincent Iacopino and Stephen N. Xenakis, 'Neglect of Medical Evidence of Torture in Guantanamo: A Case Series' (2011) 8 *PLoS Medicine* 4

Kenneth V. Iserson, 'The Limits of Health Care Resources' (1992) 10 *The American Journal of Emergency Medicine* 588

Torben Ishoy, 'Doctors and Genocide' (1995) 346 *The Lancet* 8974, 577

Alberto Jadresic, 'Doctors and Torture: An Experience as a Prisoner' (1980) 6 *Journal of Medical Ethics* 124

Fleming James, 'Scope of Duty in Negligence Cases' (1953) 47 *Northwestern University Law Review* 778

Sandra H. Johnson, 'Customary Standard of Care: A Challenge for Regulation and Practice' (2013) 43 *Hastings Centre Report* 6

Kim Johnston, 'Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives' (1998) 35 *San Diego Law Review* 951

Gregory D. Jones, '*Primum Non-Nocere*: The Expanding "Honest Services" Mail Fraud Statute and the Physician-Patient Fiduciary Relationship' (1998) 51 *Vanderbilt Law Review* 139

Paul Jung, Peter Lurie and Sidney M. Wolfe, 'US Physicians Disciplined for Criminal Activity' (2006) 16 *Journal of Law and Medicine* 335

Daniel Jutras, 'Clinical Practice Guidelines as Legal Norms' (1993) 148 *Canadian Medical Association Journal* 905

Sanford H. Kadish 'Complicity, Cause and Blame: A Study in the Interpretation of Doctrine' (1985) 73 *California Law Review* 323

Sanford H. Kadish, 'Fifty Years of Criminal Law: An Opinionated Review' (1999) 87 *California Law Review* 943

Nancy E. Kass, 'Public Health Ethics: From Foundations and Frameworks to Justice and Global Public Health' (2004) 32 *Journal of Law, Medicine and Ethics* 232

Edwin R. Keedy, 'Ignorance and Mistake in the Criminal Law' (1908) 22 *Harvard Law Review* 75

Hans Kelsen, 'Collective and Individual Responsibility in International Law with Particular Regard to the Punishment of War Criminals' (1942) 31 *California Law Review* 556

Christopher J. Kim, 'The Trial of Conrad Murray: Prosecuting Physicians for Negligent Over-Prescription' (2014) 51 *American Criminal Law Review* 517

Joseph H. King, Jr., 'In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula' (1975) 28 *Vanderbilt Law Review* 1213

Elizabeth Klumpp *et al*, 'Curbside Consultants' (2010) 7 *Psychiatry (Edgemont)* 51

Harold H. Koh, 'On American Exceptionalism' (2003) 55 *Stanford Law Review* 1479

Mark S. Komrad, 'A Defence of Medical Paternalism: Maximising Patients' Autonomy' (1983) 9 *Journal of Medical Ethics* 38

Chiara Lepora and Joseph Millum, 'The Tortured Patient: A Medical Dilemma' (2011) 41 *Hastings Centre Report* 38

Norman G. Levinsky, 'The Doctor's Master' (1984) 311 *New England Journal of Medicine* 1573

Robert J. Lifton, ‘Doctors and Torture’ (2004) 351 *New England Journal of Medicine* 415

Alexander E. Limentani, ‘The Role of Ethical Principles in Health Care and the Implications for Ethical Codes’ (1999) 25 *Journal of Medical Ethics* 394

Leslie London, Leonard S. Rubenstein, Laurel Baldwin-Ragaven, and Adriaan Van Es, ‘Dual Loyalty among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict’ (2006) 15 *Cambridge Quarterly of Healthcare Ethics* 381

David Luban, ‘Liberalism, Torture, and the Ticking Bomb’ (2005) 91 *Virginia Law Review* 1425

David Luban, Alan Strudler and David Wasserman, ‘Moral Responsibility in the Age of Bureaucracy’ (1992) 90 *Michigan Law Review* 2348

Mike Magee, ‘Relationship-Based Health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan. A Comparative Study of Patient and Physician Perceptions Worldwide’ (2003) 7 *The Journal of Biolaw and Business*

Jason Malone, ‘Derivative Immunity: The Impact of Campbell-Ewald Co. v Gomez’ (2016) 50 *Creighton Law Review* 87

Milan Markovic, ‘Can Lawyers Be War Criminals?’ (2007) 20 *The Georgetown Journal of Legal Ethics* 347

Natasa Mavronicola, ‘What is an “Absolute Right”? Deciphering Absoluteness in the Context of Article 3 of the European Convention on Human Rights’ (2012) 12 *Human Rights Law Review* 723

Allan H. McCoid, ‘The Care Required of Medical Practitioners’ (1959) 12 *Vanderbilt Law Review* 549

Helen McColl, Kamaldeep Bhui and Edgar Jones, ‘The Role of Doctors in Investigation, Prevention and Treatment of Torture’ (2012) 105 *Journal of the Royal Society of Medicine* 464

Maxwell J. Mehlman, ‘Dishonest Medical Mistakes’ (2006) 59 *Vanderbilt Law Review* 1137

Maxwell J. Mehlman, ‘Why Physicians are Fiduciaries for their Patients’ (2015) 12 *Indiana Health Law Review* 3

Theodor Meron, ‘The Geneva Conventions as Customary Law’ (1987) 81 *American Journal of International Law* 348

Daniel Messelken, ‘Conflict of Roles and Duties – Why Military Doctors are Doctors’ (2015) 1 *Ethics and Armed Forces* 44

Donald J. Meyer and Marilyn Price, ‘Peer Review Committees and State Licensing Boards: Responding to Allegations of Physician Misconduct’ (2012) 40 *Journal of the American Academy of Child and Adolescent Psychiatry* 193

Steven H. Miles, ‘Abu Ghraib: It's Legacy for Military Medicine’ (2004) 364 *The Lancet Medical Journal* 725

Steven H. Miles, ‘Medical Associations and Accountability for Physician Participation in Torture’ (2015) 17 *AMA Journal of Ethics* 945

Edward Monico *et. al*., ‘The Criminal Prosecution of Medical Negligence’ (2006) 5 *Internet Journal of Law, Healthcare and Ethics* 2

Helen Mooney, ‘US Doctors were Complicit in Guantánamo Bay Torture, Report Says’ (2011) *British Medical Journal* 342

John C. Moskop, ‘A Moral Analysis of Military Medicine’ (1998) 163 *Military Medicine* 76

Thomas H. Murray, ‘Divided Loyalties in Sports Medicine’ (1984) 12 *Physician and Sports Medicine* 134

Ralph Nader, ‘The Corporate Drive to Restrict Their Victims' Rights’ (1986) 22 *Gonzaga Law Review* 15

David J. Nicholl, Trevor Jenkins, Steven H. Miles *et al*., ‘Biko to Guantanamo: 30 years of medical involvement in torture’ (2007) 370 *Lancet* 823

Jens David Ohlin, ‘The Torture Lawyers’ (2010) 51 *Harvard International Law Journal* 193

Mark J. Osiel, ‘Obeying Orders: Atrocity, Military Discipline, and the Law of War’ (1998) *California Law Review* 1027

Suzanne Ost, ‘Breaching the Sexual Boundaries in the Doctor-Patient Relationship: Should English Law Recognise Fiduciary Duties?’ (2016) 24 *Medical Law Review* 2

Stanley L. Paulson, ‘Classical Legal Positivism at Nuremberg’ (1975) 4 Philosophy and Public Affairs 132

Andrew Perechocky, ‘Los Torturadores Medicos: Medical Collusion with Human Rights Abuses in Argentina, 1976–1983’ (2014) 11 *Journal of Bioethical Inquiry* 549

Peter B. Polatin, Jens Modvig and Thomas Rytter, ‘Helping to Stop Doctors Becoming Complicit in Torture’ (2010) 340 *British Medical Journal* 973

Frederick Pollock, ‘The Works of the League of Nations’ (1919) 35 *Law Quarterly Review* 193

Joy L. Pritts, ‘The Importance and Value of Protecting the Privacy of Health Information: The Roles of the HIPAA Privacy Rule and the Common Rule in Health Research’ (2008)

Margaret Jane Radin, ‘Reconsidering the Rule of Law’ (1989) 69 *Boston University Law Review* 781

Kelcey Raymond, ‘Merits Matter: Qualifying Government Contractor Immunity’ (2019) 48 *Public Contract Law Journal* 841

Joseph Raz, ‘Hart on Moral Rights and Legal Duties’ (1984) 4 *Oxford Journal of Legal Studies* 123

Ben A. Rich and Lynn R. Webster, ‘A Review of Forensic Implications of Opioid Prescribing with Examples from Malpractice Cases Involving Opioid-Related Overdose’ (2011) 12 *Pain Medicine* S59

Leonard L. Riskin, ‘Sexual Relations Between Psychotherapists and Their Patients: Toward Research or Restraint’ (1979) 67 *California Law Review* 1000

Marc A. Rodwin, ‘Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System’ (1995) 21 *American Journal of Law and Medicine* 243

James Ross, ‘Black Letter Abuse: The US Legal Response to Torture Since 9/11’ (2007) 89 *International Review of the Red Cross* 867

Leonard I. Rotman, ‘Fiduciary Doctrine: A Concept in Need of Understanding’ (1995) 34 *Alberta Law Review* 821

Leonard S. Rubenstein, ‘Dual Loyalties and Human Rights’ (2003) 26 *Journal of Ambulatory Care Management* 270

Leonard S. Rubenstein, ‘First, Do No Harm: Health Professionals and Guantanamo Bay’ (2007) 37 *Seton Hall Law Review* 733

Leonard S. Rubenstein, ‘Medicine and War’ (2004) 34 *Hastings Centre Report* 6

Leonard S. Rubenstein and George J. Annas, ‘Medical Ethics at Guantanamo Bay Detention Centre and in the US Military: A Time for Reform’ (2009) 374 *The Lancet* 353

Leonard S. Rubenstein and Stephen N. Xenakis, ‘Roles of CIA Physicians in Enhanced Interrogation and Torture of Detainees’ (2010) 304 *Journal of the American Medical Association* 569

Leila N. Sadat, ‘Extraordinary Rendition, Torture, and Other Nightmares from the War on Terror’ (2007) 75 *George Washington Law Review* 1200

Brian M. Serafin, ‘Comparative Fault and Contributory Negligence as Defences in Attorney Breach of Fiduciary Duty Cases’ (2008) 21 *Georgetown Journal of Legal Ethics* 993

Eileen A. Scallen, ‘Promises Broken vs. Promises Betrayed: Metaphor, Analogy, and the New Fiduciary Principle’ (1993) *University of Illinois Law Review* 897

Michael P. Scharf, ‘The Torture Lawyers’ (2009) 20 *Duke Journal of Comparative and International Law* 389

Franz B. Schick, ‘The Nuremberg Trial and the Development of an International Criminal Law’ (1947) 59 *Juridical Review* 198

Abigail Seltzer, ‘Medical Complicity, Torture, and the War on Terror’ (2010) 375 *The Lancet* 872

Marc Shalit and Matthew R. Lewin, ‘Medical Care of Prisoners in the USA’ (2004) 364 *The Lancet Special Issue* 34

Kirstyn Shaw, Christine K. Cassel, Carol Black *et al*, ‘Shared Medical Regulation in a Time of Increasing Calls for Accountability and Transparency Comparison of Recertification in the United States, Canada, and the United Kingdom’ (2009) 302 *Journal of the American Medical Association* 2008

Henry Shue, ‘Torture in Dreamland: Disposing of the Ticking Bomb’ (2006) 37 *Case Western Reserve Journal of International Law* 231

Paul Sieghart, ‘Professional Ethics - For whose Benefit’ (1982) 8 *Journal of Medical Ethics* 25

Mara Silver, ‘Testing Cruzan: Prisoners and the Constitutional Question of Self-Starvation’ (2005) 58 *Stanford Law Review* 631

Robert I. Simon and Daniel W. Shuman, ‘The Doctor-Patient Relationship’ (2007) 5 *Focus* 423

D. Gordon Smith, ‘The Critical Resource Theory of Fiduciary Duty’ (2002) 55 *Vanderbilt Law Review* 1399

Deborah Sprenger, ‘Propriety of Instruction of Jury on “Conscious Avoidance” of Knowledge of Nature of Substance or Transaction in Prosecution for Possession or Distribution of Drugs’ (1992) 109 *American Law Reports, Federal* 710

Lord Steyn ‘Guantanamo Bay: The Legal Black Hole (2004) 53 *International and Comparative Law Quarterly* 1

Eric Stover and Elena O. Nightingale, ‘The Medical Profession and the Prevention of Torture’ (1986) *The New England Journal of Medicine* 314

David Tan, ‘Sexual Misconduct by Doctors and the Intervention of Equity’ (1997) 4 *African Journal of Laboratory Medicine* 243

Nicolas P. Terry, ‘Physicians and Patients Who “Friend” and “Tweet” Constructing a Legal Framework for Social Networking in a Highly Regulated Domain’ (2010) 43 *Indiana Law Review* 285

Stephen Toulon, ‘Divided Loyalties and Ambiguous Relationships’ (1986) 23 *Social Science and Medicine* 783

Roman Veresha, ‘Criminal and Legal Characteristics of Criminal Intent’ (2017) 24 *Journal of Financial Crime* 121

Joachim Vogel, ‘How to Determine Individual Criminal Responsibility in Systemic Contexts: Twelve Models’ (2002) *Cashiers de Defense Sociale* 151

Milton C. Weinstein, ‘Should Physicians be Gatekeepers of Medical Resources?’ (2001) 27 *Journal of Medical Ethics* 268

Andrew W. Weis, ‘Qualified Immunity for Private Sector Defendants after *Filarsky* v *Delia*’ (2014) 30 *Georgia State University Law Review* 1037

David Weissbrodt, Ferhat Pekin and Amelia Wilson, ‘Piercing the Confidentiality Veil: Physician Testimony in International Criminal Trials Against Perpetrators of Torture’ (2006) 15 *University of Minnesota Law School* 72

Michael Welch, ‘American ‘Painology’ in the War on Terror: A Critique of “Scientific” Torture’ (2009) 13 *Theoretical Criminology* 451

Michael Welch, ‘Illusions in Truth Seeking: The Perils of Interrogation and Torture in the War on Terror’ (2010) 37 *Social Justice* 123

Bradley W. Wendel, ‘Defence to Clients and Obedience to Law: The Ethics of the Torture Lawyers (A Response to Professor Hatfield)’ (2009) 104 *Northwestern University Law Review* 58

Bradley W. Wendel, ‘The Torture Memos and the Demands of Legality’ (2009) 12 *Legal Ethics* 107

WMA, ‘Declaration of Malta. A Background Paper on the Ethical Management of Hunger Strikes’ (2006) 52 *World Medical Journal* 36

Bruce E. Zawacki, ‘ICU Physician’s Ethical Role in Distributing Scarce Resources’ (1985) 13 *Critical Care Medicine* 57

Online magazines

Tanya Albert, ‘Malpractice or Murder? Criminalisation of Medical Errors is a Troubling Trend’ *American Medical News* (22 October 2001)

Associated Press, ‘Anaesthesiologist Found Negligent in Boy's Death’ *The New York Times* (24 October 1996)

David Cole, ‘The Torture Memos: The Case Against the Lawyers’ *The New York Review of Books* (New York, 8 October 2009)

M. Crane, ‘Practice Medicine, Land in Jail’ *Wall Street Journal* (21 February 1995)

Mark Danner, ‘US Torture: Voices from the Black Sites’ *The New York Review of Books* (New York, 9 April 2009)

Verena Dobnik, ‘Doctor in Badly Botched Abortion is Tried for Manslaughter’ *Associated Press* (2 May 2018)

Dan Ephron, ‘The Biscuit Breaker: Psychologist Steven Reisner has Embarked on a Crusade to get his Colleagues out of the Business of Interrogations’ *Newsweek* (27 October 2008)

Peter Finn, ‘Guantanamo Closure Called Obama Priority’ *Washington Post* (Washington DC, 12 November 2008)

Lynette Holloway, ‘Abortion Doctor Guilty of Murder’ *New York Time* (9 August 1995)

International Committee of the Red Cross, United States: ICRC President urges progress on detention-related issues’ *ICRC News* (16 January 2004)

Marianne Kolbasuk McGee, ‘Former Physician Convicted of Criminal HIPAA Violation’ *Careers Info Security* (4 May 2018)

Neil A. Lewis, ‘Head of Hospital at Guantánamo Faces Complaint’ *The New York Times* (New York, 15 July 2005)

Nils Melzer, ‘Torture is Torture, and Waterboarding is not an Exception’ *UN News* (30 January 2017)

Juan Mendez, ‘If the US Tortures, Why Can’t We Do It?’ *Amnesty News* (11 December 2014)

Michael B. Mukasey, ‘Opinion’ *Wall Street Journal* (16 December 2014)

Anne M. Murphy, Laura B. Angelini and Jared Shwartz, ‘Criminal Prosecution for Violating HIPAA: An Emerging Threat to Health Care Professionals’ *STAT News* (2 July 2018)

Malathi Nayak, ‘Factbox: Has Obama Delivered on His 2008 Campaign Promises?’ *Reuters* (28 October 2011)

Dana Priest and R. Jeffrey Smith, ‘Memo Offered Justification for Use of Torture’ *Washington Post* (8 June 2004)

Thomas E. Ricks, ‘I Don’t Believe a Word of what Torture Advocates Say — And Neither Should You’ *Foreign Policy* (27 July 2015)

Danny Robbins, ‘Texas Board Won’t Discipline CIA Psychologist’ *Associated Press* (25 February 2011)

Carol Rosenberg ‘US Attorney Defends Guantánamo Hunger Striker’s Forced-Feedings’ *Miami Herald* (6 October 2014)

Brian Ross, Matthew Cole and Joseph Rhee, ‘The CIA’s $1000 a Day Specialists on Waterboarding, Interrogations’ *ABC News* (30 April 2009)

Kenneth Roth, ‘United States: Reports of Torture of Al-Qaeda Suspects’ *Human Rights Watch News* (26 December 2002)

Leonard S. Rubenstein and Stephen N. Xenakis, ‘Doctors Without Morals’ *NY Times* (28 February 2010).

Peter Slevin and Joe Stephens ‘Detainees’ Medical Files Shared: Guantanamo Interrogators’ Access Criticised’ *Washington Post* (10 June 2004)

Anthony Thornton, ‘Surgeon Was Negligent in Death, Jury Decides’ *The Oklahoman* (12 May 1998)

John Tierney, ‘Trafficker or Healer? And Who’s the Victim?’ *The New York Times* (27 March 2007)

Chuck Todd, ‘Meet the Press: Cheney on the Senate Intelligence Report’ *NBC News* (14 December 2014)

Matthew Weaver and Spencer Ackerman, ‘Trump Claims Torture Works but Experts Warn of its “Potentially Existential” Costs’ *The Guardian* (26 January 2017)

Cases

Abu Zubaydah v Lithuania (2018) ECHR 446

Abu Zubaydah v Poland (2014) ECHR

Al-Aulaqi v Obama (2010) 727 F.Supp.2d 1

Al-Laithi Set al v George Walker Bush *et al*. (2005) Civ No 05VC429

Al Nashiri v Poland (2014) ECHR 231

Al Nashiri v Romania (2018) ECHR 214

Anderson v Minneapolis, St. Paul & Sault Ste. Marie Railway (1920) 179 N.W. 45

Ange v Bush (1990) 752 F. Supp. 509

Ballard v Superior Court (1966) 410 P.2d 838

Batty v Arizona State Dental Bd. (1941) 112 P.2d 870

Berkey v Anderson (1969) 1 Cal. App. 3d 790

Billings v Sisters of Mercy (1964) 389 P.2d 224

Bouvia v Superior Court (1986) 225 Cal. Rptr. 297

Bristol & West Building Society v Mothew (1998) Ch. 1 CA

Cabalce v Thomas E. Blanchard & Associates (2015) 797 F.3d 720

Campbell v Haber (2000) 710 N.Y.S.2d 495

Campbell-Ewald v Gomez (2016) 136 S. Ct. 663

Canterbury v Spence (1972) 464 F.2d 772

Carlson v SALA Architects, Inc. (2007) 732 N.W.2d 324

Cheek v United States (1991) 498 US 192

Clanton v Von Haam (1986) 177 Ga. App. 694

Clark v Allen (1947) 331 US 503

Cobbs v Grant (1972) 502 P.2d 1

Cogswell v Chapman (1998) 672 N.Y.S.2d 460

Colorado v New Mexico (1984) 467 U.S. 310

Davis v Superior Court (1994) 33 Cal. Rptr. 2d 6

Demers v Gerety (1978) 85 N.M. 641

Diamond v Oreamuno (1969) 248 N.E.2d 910

Diggs v Arizona Cardiologists Ltd. (2000) 8 P.3d 386

Doe v Delie (2011) 257 F.3d 309

Doe v McMillan (1973) 412 US 306

Doe v Roe (1977) 92 Misc. 2d 551

Dr. Trudy Bond *et al* v Larry James (2010)

Eberhart v State (1893) 34 N.E. 637

El-Masri v the former Yugoslav Republic of Macedonia (2012) ECHR 2067

Farwell v Keaton (1976) 396 Mich. 281

Filarsky v Delia (2012) 566 US 377

Filartiga v Pena-Irala (1980) 630 F.2d876

First Tennessee Bank National Association v C.T. Resorts Co. (1995) WL 511884

Fitzgerald v State, Ala. (1896) 34, 20 So. 966

Forziati v Bd. of Registration in Med. (1955) 128 N.E.2d 789

Garcia v Coffman (1997) 946 P.2d 216

Gaynier v Ginsberg (1986) 715 S.W.2d 749

Global-Tech Appliances, Inc. v SEB S.A. (2010) 2068

Gracey v Eaker (2002) 837 So. 2d 348

Gunter v Huddle (1998) 724 So. 2d 544

Guy v Schuldt (1956) 138 N.E.2d 891

Hamdan v Rumsfeld (2006) 548 U.S. 557

Hammonds v Aetna Cas. & Sur. Co. (1965) 237 F. Supp. 96

Hardy v Brooks (1961) 103 Ga. App. 124

Harlow v Fitzgerald (1982) 457 US 800

Holtkamp Trucking Co. v David J. Fletcher, M.D., L.L.C. (2010) 402 Ill. App. 3d 1109

Hoopes v Hammargren (1986) 725 P.2d 238

Horne v Patton (1973) 291 Ala. 701, 287 So. 2d

Houghton v West (1957) 305 S.W.2d 407

Humphers v First Interstate Bank (1984) 68 Or. App. 573, 684 P.2d 581

Hundley v St. Francis Hospital (1958) 161 Cal. App. 2d 800

Hunter v Brown (1971) 484 P.2d 1162

Hurley v Eddingfield (1901) 156 Ind. 416, 59 N.E. 1058

Irvin v Smith (2001) 31 P3d 934

Ison v McFall (1964) 400 S.W.2d 243

Jerman v Carlisle, McNellie, Rini, Kramer and Ulrich LPA *et al.* (2010) 559 US 573

Kelley v Middle Tennessee Emergency Physicians (2004) 133 SW3d 587

Kiobel v Royal Dutch Petroleum Co. (2013) 133 S. Ct. 1659

Knaebel v Heiner (1983) 663 P.2d 551

Konover Dev. Corp. v Zeller (1994) 635 A.2d 798

Kozan v Comstock (1959) 270 F.2d 839

Labovitz v Dolan (1989) 545 N.E.2d 304

Lac Minerals Ltd v International Corona Resources Ltd. (1989) 2 SCR 574 (SCC) 646

Lambert v California (1957) 355 US 225

Laurie v Senecal (1995) 666 A.2d 806

Lockett v Goodill (1967) 430 P.2d 589

Lownsbury v Van Buren (2002) 762 NE2d 354

McCormick v England (1997) 494 S.E.2d 431

McGarry v J.A. Mercier Co. (1935) 272 Mich. 501, 262 N.W. 296

McKinney v Schlatter (1997) 692 NE2d 1045

McMahon v New Castle Assocs. (1987) 532 A.2d 601

Mead v Adler (2009) 231 Or App 451, 220 P3d 118

Meinhard v Salmon (1928) 164 N.E. 545

Milbank, Tweed, Hadley & McCloy v Boon (1994) 13 F.3d 537

Moragne v States Marine Lines, Inc. (1970) 398 U.S. 375

Mull v String (1984) 448 So. 2d 952

Murray v Northrop Grumman Info. Tech. Inc. (2006) 444 F.3d 169

Nardone v Reynolds (1976) 538 F.2d 1131

Nasr and Ghali v Italy (2016) ECHR 210

Natanson v Kline (1960) 350 P.2d 1093

Bang D. Nguyen v The Department of Health, Medical Quality Assurance Commission (2001) 144 WN.2d 516, 29

Oliver v Brock (1976) 342 So 2d 1, 4

O'Neill v Montefiore Hospital (1960) 11 A.D.2d 132, 202 N.Y.S.2d 436

Overstreet v TRW Commercial Steering Div. (2008) 256 S.W.3d 626, 641

Palsgraf v Long Island Railroad Company (1928) 248 N.Y. 339, 162 N.E. 99

Payton v Weaver (1982) 131 Cal.App.3d 38

Pedesky v Bleiberg (1967) 251 Cal. App. 2d 119

People v Middleton (1976) 350 N.E.2d 223

People v Stuart (1956) 302 P.2d 5, 9

People ex rel. Dept. of Corrections v Fort (2004) 352 Ill.App.3d 309

Peterson v St. Cloud Hosp. (1990) 460 N.W.2d 635

Petrillo v Syntex Labs. (1986) 148 Ill. App.3d

Piller v Kovarsky (1984) 194 N.J. Super. 392, 476 A.2d 1279

Powell v Schriver (1999) 175 F.3d 107

Preston v Hubbell (1948) 87 Cal. App. 2d 53

Prosecutor v Šešelj (2006) ICTY

QT Inc. v Mayo Clinic Jacksonville (2006) U.S. Dist. LEXIS 33668

Raptis-Smith v St. Joseph's Med. Ctr. (2003) 302 A.D.2d 246, 755 N.Y.S.2d 384

Ratzlaf v United States (1994) 510 U.S. 135

Rasul v Bush (2004) 542 U.S. 466

Re Caulk (1984) 125 N.H. 226, 231

Re Revocation of License of Kindschi (1958) 52 Wn.2d 8, 319 P.2d 824

Re Winship (1970) 397 U.S. 358

Reisner v Catone (2011) 929 N.Y.S.2d 403

Reynolds v Decatur Memorial Hospital (1996) 660 N.E.2d 235

Rice v Perl (1982) 320 N.W.2d 407

Ricks v Budge (1937) 91 Utah 307, 64 P.2d 208

Roberts v Galen of Virginia, Inc. (1999) 525 U.S. 249, 119 S. Ct. 685

Rylands v Fletcher (1868) 3 LRE & I App. 330 (HL)

Safer v Estate of Pack (1996) 291 NJ Super 619, 677 A2d 1188

Sampson v Hunt (1983) 665 P.2d 743

Sarim v Medical Board of California (2006)

Suleiman Abdullah Salim, *et al*., v James E. Mitchell and John Jessen (2018) 2:15-CV-286-JLQ

Seaton v. Mayberg (2010) 610 F.3d 530

Smith v Tele-Commc'n, Inc. (1982) 184 Cal. Rptr. 571

Sosa v Alvarez-Machain (2004) 542 US 692.

St. John v Pope (1995) 901 SW2d 420

State v Herendeen *et al* (2005) 279 Ga 323, 613 SE2d 647

State v Weiner (1964) 21, 194 A.2d 467

Sterling v Johns Hopkins Hospital (2002) 145 Md.App. 161, 187, 802 A.2d 440

Strauss v Biggs (1987) 525 A.2d 992, 998

Taber v Riordan (1980) 403 N.E.2d 1349, 1353

Tarasoff v Regents of the University of California (1976) 17 Cal.3d 425,551 P2d 334

Tel-Oren v Libyan Arab Republic (1984) 726 F.2d 774

Terlinden v Ames (1902) 184 US 270

The Head Money Cases (1884) 112 US 580

The People v Einaugler (1994) 618 NYS2d 414

Thor v Superior Court (1993) 855 P.2d 381

Thornton v State (2007) 397 Md. 704

Trans World Airlines Inc v Franklin Mint Corp (1984) 446 US 243

Trombley v Kolts (1938) 29 Cal. App. 2d 699, 85 P.2d 541

US v Blair (1995), 54 F.3d 639

US v Calley (1974) 48 C.M.R. 19

US v Feingold (2006) 454 F.3d 1001

US v Hurwitz (2006) 459 F.3d

US v Katz (2006) 445 F.3d 1023

US v MacKay (2014) 20 F. Supp. 3d 1287

US ex rel. Saroop v Garcia (1997) 109 F3d 165

Wheeler v Barker (1949) 92 Cal. App. 2d 776

Wilkins v Lasater (1987) 733 P.2d 221

Wilmington General Hospital v Manlove (1961) 174 A.2d 135

Winters v New York (1948) 333 U.S. 507

Woolley v Henderson (1980) 418 A.2d 1123, 1128 n.3

Yearsley v W.A. Ross Const. Co. (1940) 309 US 18

Youngstown Sheet & Tube Co. v Sawyer (1952) 343 US 579

Zackiva Commc'ns Corp. v Horowitz (1993) 826 F. Supp. 86

Complaints

Complaints to the Medical Board of California by Sarim *et al*. against John Edmondson (11 July 2005)

Complaint to the Louisiana State Board of Examiners of Psychologists by Dr Trudy Bond against Larry James (29 February 2008)

Complaint to the Ohio State Board of Psychology by Michael Reese, Trudy Bond, Colin Bossen, and Josephine Setzler against Larry James (7 July 2010)

Complaint to the New York Office of Professional Discipline by Trudy Bond against John Leso (5 April 2007)

Complaint to the Texas State Board of Examiners of Psychologists by Jim Cox against James Mitchell (17 June 2010)

Complaint to the Medical Board of California by Dr David Nicholl (26 January 2006)

Complaint to the Alabama Board of Examiners by Dr Trudy Bond against Dr Diane Zierhoffer (21 November 2008)

Letter from Carolyn Knauss, Investigator, to Dr Trudy Bond (16 September 2008)

Letter from Jim H. Mcnatt, MD, Medical Director, Georgia Composite State Board of Medical Examiners, to Dr David Nicholl (26 June 2007)

Legislations

International

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment (UN CAT)

Convention on Certain Conventional Weapons (UN CCW)

Geneva Conventions

International Covenant on Civil and Political Rights (ICCPR)

Rome Statute of the International Criminal Court

US

Alabama Medical Practice Act

Alien Tort Claims Act

Detainee Treatment Act of 2005

Model Penal Code

Ohio Administrative Section

Restatement (Second) of Torts

Revised Statutes of Missouri

Texas Government Code

Uniform Code of Military Justice

Medical Norms

American Medical Association (AMA) Code of Medical Ethics

AMA Code of Medical Ethics Opinion 2.1.1.

AMA Code of Medical Ethics Opinion 3.3.1.

AMA Criminalisation of Medical Judgment Resolution 223

AMA Obtaining a Medical License

AMA Opinion 2.067 (1999)

AMA Principles of Medical Ethics IV

American Psychiatric Association (APA), 'Position Statement on Psychiatric Participation in Interrogation of Detainees' (September 2008)

APA Presidential Task Force, Psychological Ethics and National Security (2005)

APHA Task Force on Correctional Health Care, *Standards for Health Services in Correctional Institutions* (American Public Health Association: Washington, DC, 2003)

BMA Ethical Decision-Making for Doctors in the Armed Forces: A Toolkit

NCCHC, *Standards for Health Services in Jails* (National Commission on Correctional Health Care: Chicago, IL, 2008)

State Regulations Pertaining to Clinical Records

US Office of the Assistant Secretary for Planning and Evaluation, 'Standards for Privacy of Individually Identifiable Health Information' (2000)

World Medical Association (WMA) Declaration of Malta on Hunger Strikes

WMA Declaration of Tokyo on Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (October 1975)

WMA International Code of Medical Ethics

Military Norms

Executive Order No. 13492 (22 January 2009)

US Armed Forces, 'Joint Chief of Staff United States Manual on Detainee Operations' (2008)

US Army Inspector General, 'Detainee Operations Investigation' (Department of the Army, 2004)

US Army Report and Message Formats, Field Manual 101-5-2

US Assistant Secretary of Defense, 'Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the US' (2005)

US Department of Defence, 'Directive 2311.01E. Medical Program Support for Detainee Operations' (2006)

US Department of the Air Force, 'Air Force Pamphlet 110-34, Commander's Handbook on the Law of Armed Conflict (1980)

US Department of the Air Force, 'Instruction 1.1.' (2012)

US Department of the Army, 'Army Regulation 600-20. Army Command Policy'

US Department of the Army, 'Field Manual 27-2. The Law of Land Warfare' (1956)

US Department of the Army, 'Field Manual 27-10. The Law of Land Warfare' (1956)

US Department of the Army, 'US Army Human Intelligence Collector Field Manual' (2014)

US Department of the Army, 'Instructor's Guide - The Law of War (1985)

US Department of the Navy, 'Change to US Navy Regulations in Light of US v Serianne' (2010)

US Uniform Code of Military Justice

Official Documents

International

Inter-American Commission on Human Rights, 'Statement of the United Nations Special Rapporteur on torture at the Expert Meeting on the situation of detainees held at the US Naval Base at Guantanamo Bay (3 October 2013)

US

Steven G. Bradbury, 'Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques that May be Used in the Interrogation of a High-Value al Qaeda Detainee: Memorandum to John A Rizzo' (2005)

John O. Brennan, ‘Statement on SSCI Detention and Interrogation Program’ (11 December 2014)

George W. Bush, ‘Declaration of National Emergency by Reason of Certain Terrorist Attacks’ (14 September 2001)

George W. Bush, ‘Memorandum to Vice President, Secretary of State, Secretary of Defence, *et.al.*, Re: Humane Treatment of al Qaeda and Taliban Detainees’ (7 February 2002)

Jay S. Bybee, ‘Memorandum to Alberto R. Gonzales, Standards for Conduct for Interrogation under 18 U.S.C. 2340 - 2340A’ (1 August 2002)

Jay S. Bybee, ‘Memorandum to William J. Haynes, Re: Application of Treaties and Laws to Al Qaeda and Taliban Detainees’ (22 January 2002)

Central Intelligence Agency, ‘Comments on the Senate Select Committee on Intelligence Report on the Rendition, Detention, and Interrogation Program’ (27 June 2013).

Barack Obama, ‘Statement on Release of OLC Memos’ (16 April 2009)

John C. Yoo, ‘Memorandum to William J. Haynes, Application of Treaties and Laws to Al Qaeda and Taliban Detainees’ (9 January 2002)

John C. Yoo, ‘Memorandum to William J. Haynes II’ (2003)

John C. Yoo, ‘Memorandum to Tim Flanigan, The President's Constitutional Authority to Conduct Military Operations Against Terrorist and Nations Supporting Them’ (25 September 2001)

US Department of Defence, ‘Instruction 2310.08E, Medical Program support for detainee operations’ (6 June 2006)

US Department of Justice Office of Legal Counsel, ‘Memorandum for John A. Rizzo, Interrogation of Al-Qaeda Operative’ (1 August 2001)

William Taft IV, ‘Memorandum to John Yoo, Re: Yoo Draft Memorandum of January 9, 2002’ (11 January 2002)

Websites

Alabama Board of Medical Examiners, ‘Filing a Complaint’ https://www.albme.org/Documents/cmpltinstrrel.pdf.

Centre for Constitutional Rights, ‘When Healers Harm: Hold Health Professionals Accountable for Torture’ https://ccrjustice.org/when-healers-harm-hold-health-professionals-accountable-torture

Health Information and the Law, ‘Who Owns Medical Records: 50 States Comparison’ http://www.healthinfolaw.org/comparative-analysis/who-owns-medical-records-50-state-comparison

ICC https://www.icc-cpi.int/afghanistan

Physicians for Human Rights http://physiciansforhumanrights.org/about/

University of Denver Private Security Monitor, ‘Department of Defence Regulations and Instructions’ http://psm.du.edu/national_regulation/united_states/laws_regulations/defense.html.

Reports

Amnesty International, ‘Doctors and Torture’ (2002)

Amnesty International ‘Report 2003 – the United States of America’ (2003)

Amnesty International, ‘Unlawful Detention of Six Men from Bosnia-Herzegovina in Guantánamo Bay’ (2003)

Amnesty International, ‘USA: Human Dignity Denied: Torture and Accountability in the “War on Terror”’ (2004)

Gretchen Borchelt, ‘Break Them Down’ (Physicians for Human Rights, 2005)

Centre for Constitutional Rights, ‘Report on Torture, Cruel, Inhuman and Degrading Treatment of Prisoners at Guantanamo Bay, Cuba’ (2006)

Anne Daugherty Miles, ‘Perspectives on the Senate Select Committee on Intelligence (SSCI) “Torture Report” and Enhanced Interrogation Techniques: In Brief’ (2015)

European Centre for Constitutional and Human Rights (ECCHR) and Public Interest Lawyers (PIL), ‘Communication to the Office of the Prosecutor of the International Criminal Court, The Responsibility of Officials of the United Kingdom for War Crimes Involving Systematic Detainee Abuse in Iraq from 2003-2008.’

Federation of State Medical Boards, ‘Essentials of a State Medical and Osteopathic Practice’ (2012)

Federation of State Medical Boards, ‘US Medical Regulatory Trends and Actions’ (2018)

Farnoosh Hashemian *et al*., ‘Broken Laws, Broken Lives: Medical Evidence of Torture by the US Personnel and Its Impact’ (Physicians for Human Rights, 2008)

REDRESS and FIDH, ‘Strategies for the Effective Investigation and Prosecution of Serious International Crimes. The Practice of Specialised War Crime Units’ (2010)

Institute of Medicine, Committee on Clinical Practice Guidelines, ‘Guidelines for Clinical Practice: Front Development to Use’ (National Academy Press: Washington, DC, 1992)

Institute on Medicine as a Profession and OSF Joint Task Force Guantanamo Bay, ‘Medical Management of Detainees with Weight Loss’ (2013)

Institute on Medicine as a Profession and OSF Joint Task Force Guantanamo Bay, ‘Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror’ (2013)

International Committee of the Red Cross, ‘Report on the Treatment of Fourteen “High-Value Detainees” in CIA Custody’ (2007)

International Helsinki Federation for Human Rights, ‘Anti-terrorism Measures, Security and Human Rights: Developments in Europe, Central Asia and North America in the Aftermath of September 11’ (2003)

Dick Marty, ‘Alleged Secret Detentions and Unlawful Inter-state Transfers of Detainees Involving Council of Europe Member States’ (2006)

The project of the International Dual Loyalty Working Group, ‘Dual Loyalty in Health and Professional Practice: Proposed Guidelines and Institutional Mechanisms’ (Physicians for Human Rights and the University of Cape Town Health Sciences Faculty; Cape Town, South Africa, 2002)

Nathaniel Raymond *et al*, ‘Experiments in Torture: Evidence of Human Subject Research and Experimentation in the “Enhanced” Interrogation Program’ (Physicians for Human Rights, 2010)

James R. Schlesinger, ‘Final Report of the Independent Panel to Review DoD Detention Operations’ (2004)

Senate Select Committee on Intelligence, ‘Committee Study of the Central Intelligence Agency’s Detention and Interrogation Program’ (3 December 2014)

Antonio Taguba, ‘Taguba Report. Article 15-6 Investigation of the 800th Military Police Brigade’ (2003)

US Department of Justice Office of Legal Counsel, ‘Background Paper on CIA’s Combined Use of Interrogation Techniques’ (2004)

US Office of the Surgeon General Army, ‘Final Report. Assessment of Detainee Medical Operations For OEF, GTMO, OIF’ (2005)