

**REPORT BY
VIVIENNE HILARY NATHANSON
TO THE BAHAMOUS PUBLIC INQUIRY**

Declaration:

I have prepared this Report at the request of the Bahamian Public Inquiry. I confirm my understanding that it is my overriding duty to assist the Inquiry on the matters within my expertise as detailed in the Report in the same way that would apply under Part 35 of the Civil Procedure Rules and the associated Practice Direction and Annex as if it were evidence provided before a court of law. I also confirm that I shall continue to comply with that duty in relation to any further written or oral evidence I may provide to the Inquiry.

Vivienne Nathanson

September 2010

MIV008998

1. I am Vivienne Hilary Nathanson. I am Director of Professional Activities at the British Medical Association, with responsibilities encompassing all the non trades-union work of the Association such as ethics, public health, human rights and education.
2. I am also currently an honorary professor of ethics at the School for Health at Durham University. I have lectured and written on ethics and human rights for over 25 years, in the UK and internationally. As part of the UK delegation I have led World Medical Association work on human rights in relation to medicine and ethics for 15 years, including revision of core texts referred to below.
3. In my report I refer to a number of key ethics texts. Full references are included. All WMA documents are available on the WMA website. Throughout the report I refer to the ethical duties on physicians. It should be understood that in modern health care settings all health care clinical workers would be expected to work to the same ethical standards. As doctors are commonly leaders and managers of clinical teams they have specific responsibilities to ensure that they and the staff under their management or command also follow good ethical practice.

Q1. What ethical duties are owed by medics in the Armed Forces to captured persons?

4. It should be understood that “medical treatment”, in terms of medical ethics, includes diagnosis, management and treatment, public health and illness prevention, not merely active interventions for acute and ongoing ill health.
5. Wherever the doctor practices s/he owes the same set of ethical duties to his/her patients. This includes the duty of care and more specific duties around confidentiality, consent, access and all other areas. Doctors also have duties to keep themselves up-to-date and well informed so they can offer optimum care to their patients.

6. This is traditionally spelt out in medical ethics with reference to the Hippocratic Oath or to the World Medical Association (WMA) Declaration of Geneva and International Code of Medical Ethics (a modern restatement of the Hippocratic Oath)(MIV008375) , or indeed to the Nuremberg Codes. It is recognised by commentators on the implementation of these codes that they need interpretation and understanding as they are applied to different clinical scenarios. This does not mean that the principles are different, merely that how they are put into operation needs careful analysis. The health management of detainees in a military setting, including in areas of active conflict, is thus no different from any other medical setting in terms of the applicability of the principles.
7. It is recognised in the ethics literature that particular problems arise where the doctor may have dual responsibilities or obligations; to his/her employer (in this case the military and chain of command) and to the patient. The overriding duty is to the patient. This is expressed in the WMA Declaration of Geneva) which can be found at MIV008375) as “The health of my patient will be my first consideration”.
8. Doctors are advised throughout ethics literature and in ethics training to recognise that, in examining, diagnosing, treating, managing and advising a patient, they are always first and foremost a doctor with a responsibility to that patient. This is the underlying tenet of “Good Medical Practice” (MIV 002705 –MIV02755), the General Medical Council’s central set of ethical advice to doctors registered in the UK, which says “make care of your patient your first concern”.
9. The duty of a doctor not to discriminate unfairly in any way is in both the Declaration of Geneva and the first principle of a WMA set of regulations on medical practice in times of armed conflict which can be found at MIV008378.
10. Paragraph one states; *“Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their*

patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.”

11. Doctors have a duty to attempt to understand the matters that will affect the health of their patients, including the environment within which they are living, the resources available to them in offering treatment, the constraints that might apply and the impact of those constraints on the individual patient. This means that they should make reasonable efforts to attain any information relevant to these factors.
12. It follows that doctors have an ethical duty to understand the circumstances in which a detainee is going to be held, and the impact that will have on his/her health including the management of any underlying medical condition. In the same way that failing to meet acceptable standards of knowledge and care is ethically unacceptable, so is failing to act on knowledge about prison or other conditions.
13. It also follows that where the patient is incarcerated – a detainee in a military setting or a prisoner in a civil setting – the doctor must understand the environmental impact of detention. It is clearly unethical for a prison doctor to ignore the implications of, for example, an outbreak of tuberculosis in a prison and to consider this when advising on the care of the individual. Similarly if there is a widespread practice of the use of conditioning techniques, or of extrajudicial punishments, the doctor must attempt to make him/herself aware and act on that awareness.
14. There is a separate duty under international human rights instruments to prevent torture and cruel, inhuman and degrading treatment. The obligation on doctors in respect of this duty is identified in the UN Principles of Medical Ethics in the Protection of Prisoners and Detainees etc.¹
15. The doctor also has specific ethical duties to use his/her knowledge to prevent abuse or the continuation of conditions inimical to health. Advice on what that means is available from the BMA, the WMA website and many

¹ Quoted in full at MIV012012-13

ethics literature sources, including, for example, “Dual Loyalty and human rights in Health Professional Practice”², a report of an international project which looked at all circumstances of dual loyalties or obligations and set out clear brief guidance on what the doctor must/must not do.

16. In terms of torture and cruel inhuman and degrading treatment, the WMA Declaration of Tokyo MIV008380 in its first clause prohibits any involvement by physicians in such practices. The words used are carefully selected. In prohibiting physicians “to countenance and condone” it is clear that absence of action to oppose such practices is inherently unacceptable.
17. Given that doctors thus have two ethical obligations: to understand the environment within which the detainee will be held, and not to countenance or condone practices which are cruel etc, it follows that military physicians overseeing persons in detention have an obligation to ensure that their patients are not subject to illegal or other unacceptable practices, and if they are, to do everything in their power to stop such practices.
18. If doctors suspect practices that are harmful to the health and wellbeing of their patients, they must make enquiries to verify or allay their suspicions. Failing to act on such suspicions is ethically unacceptable. If the doctor individually cannot obtain the relevant information, s/he must escalate enquiries through the appropriate channels and assure him/herself that proper enquiries are underway in a timely manner.
19. Specific advice on how to stop such practices will vary according to the situation. In terms of UK military physicians, this must include reporting using local command structures and the separate medical hierarchy. Failing to use those systems is arguably a breach of medical ethics.
20. Ethical duties relating to core matters such as consent and confidentiality are the same as in medical practice elsewhere, but there are specific tensions in military medicine around confidentiality. These primarily relate to commanding officers needing information about the health status of their troops, rather than of detainees. There are well established protocols for

² Dual Loyalty and Human Rights In Health Professional Practice. 2002, ISBN 1-879707-39-X (MIV008944)

handling this situation. In the case of detainees, physicians have to be aware of the risk that those outside the medical hierarchy may wish to see medical information because it could be used within an interrogation or questioning situation. In terms of prisoners and detainees, the key factor is ensuring that notes made for medical reasons are not accessed by others or used to support non-medical interventions, including interrogation.

21. In terms of consent, there are considerable variations across international legislatures on the legal requirements and definitions but the ethical standards are the same. These are that consent must be free and adequately informed.
22. In the UK the BMA explains this to doctors as embodying the concept of real or valid consent.³ To consent a patient must be competent and have enough information to understand that s/he has a choice, what that choice is and to be able to make the choice without coercion. This is not the same as the US model of “fully informed” consent where there are arguments about what constitutes full information. The UK understanding requires the physician to offer information to the patient and to encourage them to consider all the major elements to the decision, recognising that different patients find some information of more importance than others. It is rare in UK law to require consent to be written and witnessed; ethical norms do not require this.
23. Individual consent is required for all medical interventions from competent patients apart from generalised population-wide public health interventions. In practice necessarily implied consent is recognised as appropriate in many circumstances, such as those of a normal medical examination, again from competent patients. Thus if a patient presents to a doctor with symptoms the doctor will say that an examination is needed and the patient signifies compliance or consent by lying on an examination couch, or undressing or a similar action. In the detainee situation the key to consent to examination is almost certainly about trust – in the doctor, in the procedure and its purpose. In detention setting using a recorded and witnessed consent process is sensible, but not essential. Recognising that understanding the process and

³ Medical Ethics Today; the BMA’s handbook of ethics and law. Pub BMJ books, 2004 ISBN 0 7279 1744 7, pages 2-164 (MIV008948)

the choices inherent within it are essential elements, the consent form must be available in relevant local languages and, if necessary, read aloud to a functionally illiterate patient.

24. There are occasions when competent patients refuse consent to a medical examination. If the patient is incompetent – by reason of illness or injury – doctors will examine and indeed start treatment without consent. This is routine and well understood by all doctors. Ethics advice would be not to force an examination. There is an exception; where the patient is felt to be at imminent risk of death if an examination is refused or indeed if treatment is refused. In UK law competent patients may refuse examination, treatment or any other intervention even in these circumstances, but the details must be clearly documented. In practice the only non-consensual treatment that can be carried out is for mental health and it must be only that which is immediately necessary.
25. Recognising that detainees are at increased risk of suffering injury during their detention, including self harm, harm by other detainees and by the authorities, it is well established that all detainees should be examined formally on admission to and discharge from detention.
26. Detainees in all custodial settings face specific risks. The fact of detention in and of itself may induce or worsen psychological problems and increase the risk of self harm. In situations where there is overcrowding in the physical facility, whether in prison, police or other detention centres, the risk of harm by others is increased, but can be reduced by careful system reform, including surveillance and people management. The risk of harm by the authorities depends upon the ethos within the detention setting, including the perception by those in positions of power about whether abuse is tolerated or not, and their perception of the likelihood of being observed or noted to have abused someone, and swingeing penalties being applied to the abuser. One part of the system for ensuring abuse does not happen is monitoring, including a careful and up-to-date medical examination on entry to detention, of all sorts. This ensures that there is a formal record of a detainee's pre-detention health and wellbeing, and that changes to that can be clearly linked to conditions inside detention.

Q2. Is it ethically appropriate for medics to certify or confirm whether detainees are *fit for detention* and/or *fit for questioning*?

Alternatively should they merely advise on medical interventions that are necessary e.g., that a detainee should not be detained because he/she needs immediate hospital treatment or that a detainee should not be questioned because it may be harmful to a detainee's mental health?

27. It is wholly unacceptable for a physician to certify fitness for detention or for interrogation. Tensions arising from dual obligations in a custodial setting may mean that it is difficult wholly to distinguish between certifying fitness for detention and providing necessary medical support to a detainee in these circumstances.
28. It is clearly ethical for a physician to advise on the specific circumstances of an individual's detention, for example requiring a specific diet, elements of medical care or, indeed, release from detention in relation to serious mental or physical health problems. This does not amount to stating that an individual is fit for detention, but that there are no medical reasons for the doctor to intervene in the due process through which the individual is going.
29. If a doctor certifies fitness for detention/interview/interrogation that places the physician in a position where s/he will be seen to accept the practice for which they are certifying fitness. It inevitably places the physician in the role of part of the detention/interrogation process and removes them from the role of physician caring for the patient. Even if the detention is not designed to harm the detainee it is clearly not designed to maintain or improve their health, which is the only role the physician fulfils.
30. In police custody in the UK forensic physicians may be called to advise on fitness for custody and/or questioning. They will not see all those arrested, only those about whom the custody officer has medical concerns. A person who appears confused or unable to walk in a straight line might have suffered a head injury and be exhibiting early signs of brain injury, or be drunk or under the influence of drugs. The doctor is assessing whether they

need immediate medical treatment or not. In terms of questioning s/he will be examining to consider whether their “confused” state is such that they would be mentally competent to answer questions, and therefore whether their answers would have evidential value.

31. There is a key additional point; the context. In UK police custody rules and procedures have been developed to protect the detainee from abuse, including the rules laid down under relevant legislation such as the Police and Criminal Evidence Act. All interviews are recorded and witnessed and the interviewee has the opportunity to be legally represented. These procedures ensure that his/her human rights and liberties are not infringed.
32. The same does not exist within the circumstances being considered in this case, and the comparison is therefore further weakened. It is a contravention of Principles 3 and 4 (a) of the UN Principles of Medical Ethics for physicians to “fit” prisoners for interrogation as seen in the document at MIV012012

Q3. When, if ever, should medical examinations take place if a detainee withholds consent to being examined?

33. Examinations without consent should not take place. If there is a real and well founded concern that the detainee is at risk of serious harm, perhaps from a previous injury or illness, which must be assessed so that life preserving treatment can be offered, it is clear that considerable efforts must be made to persuade, but not coerce, the individual to agree. Recognising that the major reason for refusal will be suspicion about the motivation behind the request to examine, points to the need to attempt to increase the trust by being as explicit and detailed as possible about the non involvement of the physician in the process of detention or of interrogation. A competent patient may refuse even life saving treatment. Detainees must not be offered a lesser level of freedom to make decisions. It is essential that an adequate examination of decision-making capacity and mental health is undertaken to ensure that an individual refusing examination is not incompetent. When examining an incompetent patient, the examination

must be based on the clinical need and limited to the bare essentials to ensure the welfare and safety of the individual. Careful documentation of the processes gone through to attempt to achieve consent is essential. It is also advised that examination is offered on more than one occasion.

Q4. What are the ethical duties of a medic who suspects that a detainee has been mistreated?

34. A doctor suspecting mistreatment has an absolute ethical obligation to act on behalf of his/her patient. This means immediately seeking to stop the abuse. We advise doctors, for example in the prison medical services, to immediately approach the senior responsible person. In prison terms, this may be a more senior doctor or the governor. If that person fails to act, the doctor should then use medical routes wherever possible to alert authorities with the power to intervene. In military terms, this means using general command structures and medical hierarchical structures. If there are other doctors in the institution who are seeing the same group of individuals, the doctor should discuss his/her concerns so that they are alerted to look even more carefully for signs of abuse. In civilian practice doctors can consider using non-state organs such as the WMA to escalate unmet concerns about abuse; this should be considered in guidance to military medics.

Q5. As to SGOPL 9/09 (and Air Commodore Wilcock's evidence as to SGOPL 9/09)

(i) Do you agree with the ethical guidance given at paras 5 to 6

35. Generally speaking these ethical rules are well set out and cover the major issues. It is essential to note that while directed at doctors, and referring in paragraph 5 b (MIV002685) to medical practitioners being barred from participating in torture, this prohibition extends to everyone. The rules cited are specific UN rules on the practice of doctors, but apply to all health care personnel in modern practice.

36. In paragraph 5 f restraint of prisoners or detainees on the basis of medical criteria is discussed. This is and should be a rare and exceptional case. In my view it is essential that illustrative examples are offered to demonstrate how unusual such circumstances will be.
37. In paragraph^{6 c} (MIV002686) reference is made to medical discharge. It should be clarified that this could be on the grounds of physical or mental health.

In particular, do you agree with the policy in SGOPL 9.09 that health personnel are “not to...[certify or state] that a detainee meets a specific mental or physical standard for interrogation”? Do you agree with the intention (described by AC Wilcock) to “ensure that there is no deliberate temporal relationship between the medical examination and any interrogation”? Is it ever in the interests of a captured person that he be examined prior to questioning or interrogation?

38. It is clearly in the interests of the detainee or captured person that s/he is examined as soon after capture as possible, and before interrogation. It is this process which should highlight serious and potentially life threatening medical concerns, which might make detention wholly inappropriate. I agree that there should be no formal temporal relationship.
39. The problem with establishing a formal temporal relationship between the medical examination and any interrogation is that it will be seen by some and portrayed by more as “fitting” the detainee for interrogation. There is a tension here between separating the examination and the other elements of detention and interrogation, and ensuring that there is a detailed knowledge of the CPERS’ pre-detention health and wellbeing. It is clearly in the interest of the CPERS to have a medical examination performed as soon as possible after detention. This should not be a certificate of fitness for detention or interrogation but identify specific medical needs that are inconsistent with detention and/or interrogation. It will also act as a “zero-point” reference for future examinations, and therefore reinforce to the

CPERS and his/her captors, that the CPERS has the right not to be subject to abuse.

Is the approach to “*consent*” described in para 10 of AC Wilcock’s statement appropriate?

40. This is the correct general approach to consent, but even if followed to the letter it could lead to failure to obtain real, free and valid consent. It should be understood that consent is not an event but a process, in which doctor and patient discuss what will be done and agree to proceed. The patient must have the ability to understand and it may therefore be necessary to enrol professional translators. If individuals refuse to consent due to a lack of appropriate explanation and discussion, this is a serious failure by the doctor. In the absence of appropriate explanation and discussion, consent will not be valid.

As to the remainder of SGOPL 9/09, does any of it give you any concerns about whether it is ethically appropriate?

41. SGOPL 9/09 at paragraph i (3) (MIV 002688) states that medical examinations should be conducted at least once a month. This should clearly be a minimum requirement. Doctors should consider the individual and the circumstances in the place of detention. If there is concern about, for example, tuberculosis or other contagious illness, examinations should be more frequent. Given the incidence of serious mental health problems among detainees, examinations should specifically include a check on mental health status.
42. Given that there was, apparently, a remarkable level of ignorance about the rules applicable to the health care of detainees, the medical command structure should consider commissioning E-learning or other support modules on SGOPL 9/09 and the general principles behind it, and expect doctors in the field to access such learning on a regular basis.

Statement of Truth

I believe the facts stated in this witness statement are true.

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Signed

Vivienne Hilary Nathanson

Dated 21 September 2010