

Society of General Internal Medicine
Position on Physician Participation in Torture

2018

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**Global Health and Human Rights Interest Group, Ethics Committee, and Health
Policy Committee**

The Society of General Internal Medicine resolves that health care professionals, with a specific focus on physicians,

- Shall not knowingly provide any research, instruments, or knowledge that facilitates the practice of torture or other forms of cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment;
- Shall not knowingly participate in any procedure in which torture or other forms of cruel, inhuman, or degrading treatment or punishment is used or threatened;
- Shall attempt to stop torture or other cruel, inhuman, or degrading treatment or punishment, where a health care professional is present, and failing that, exit the procedure;
- Shall be alert to acts of torture and other cruel, inhuman, or degrading treatment or punishment and have the ethical responsibility to report these acts to the appropriate authorities.
- Shall not participate in interrogation of detainees. This includes providing medical clearance for interrogation, treating or reviving interrogates during questioning, monitoring interrogations or helping design interrogations(1)
- Shall not force feed detainees participating in voluntary protest fasting (“hunger strikes”)(2-5)

The Society of General Internal Medicine believes the Department of Defense should

- ensure that military health care provider’s first ethical obligation is to the patient.
- excuse health care professionals from performing medical procedures that violate their professional code of ethics (6)
- implement the recommendations of the Defense Health Board Ethics Subcommittee related to training of military health professionals in concepts of dual loyalty and ethics of combat to ensure maintenance of high ethical standards of health professionals in the field of operation. (6)

Furthermore, the Society of General Internal Medicine believes health professionals who are convicted of acts of torture or other forms of cruel, inhumane and degrading treatment or punishment shall be subject to revocation of licensure to practice in the United States.

BACKGROUND

The existence of state-sponsored torture and other cruel, inhuman, or degrading treatment or punishment has been documented in many nations around the world. Unfortunately, there have also been numerous credible reports of medical involvement in interrogation, including practices that violate international prohibitions of torture or cruel, inhuman or degrading treatment. The victims of such insults may suffer from long-term, multiple psychological and physical health problems. Rights of individuals protecting them from inhuman or degrading treatment are supported by both prominent constructs from moral philosophy and international human rights law. (United Nations, 1975)

The **Society of General Internal Medicine (SGIM)**, founded in 1978, is an international organization representing more than 2800 primary care/general internal medicine clinicians, educators, and researchers. The central mission of the organization is the pursuit of excellence in patient-centered, scientifically sound medical care, research, and education. The Society also sees as its mission the active promotion of social responsibility and the health of vulnerable, under-served, and diverse populations.

It is in this context that SGIM joins with other medical and public health organizations (*American Medical Association, American Psychological Association, American College of Physicians, American Public Health Association, World Medical Association, Physicians for Human Rights*) in their official condemnation of physician participation in torture and other cruel, inhuman, and degrading treatment or punishment in all its forms.

THE LEGAL ARGUMENT:

International Humanitarian Law and the Geneva Conventions

International humanitarian law is founded on the principles of humanity, impartiality, and neutrality. The development of modern international humanitarian law can be credited to the efforts of a 19th Century Swiss businessman, Henry Dunant. The International Committee of the Red Cross (ICRC) was formed in Geneva in 1863 as a result of Dunant's work, *A Memory of Solferino*.

Later that same year diplomats from 16 nations participated in *The Geneva Convention*, the contents of which asserted that citizens who assist the wounded are to be protected, and wounded or sick combatants are to be collected and cared for by either side in a conflict. This agreement became the foundation of modern international humanitarian law, which now includes four *Geneva Conventions of 1949* (ratified by the United States in 1955) and two additional *Protocols (1977)*. These four Geneva Conventions specifically addressed: the *Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*; the *Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea*; the *Treatment of Prisoners of War*; and the *Protection of Civilians in Time of War*.

With respect to prisoners of war (POWs), the Conventions state POWs must be respected and protected without discrimination; must not be murdered or exterminated; and must not be subjected to torture or medical experimentation. They must be protected against acts of violence, insults, and public curiosity; treated humanely, adequately housed, and should receive sufficient food, clothing, and medical care. Female POWs must be treated with regard due their sex. As defined in the Geneva Conventions, POWs include members of the armed forces, volunteer militia (including resistance movements), and civilians accompanying the armed forces. Captors must not engage in any reprisals or discriminate on the basis of race, nationality, religious beliefs, political opinions, or other criteria.

In terms of protection of civilians, the Geneva Conventions state that civilians are to be protected from murder, torture, or brutality, and from discrimination on the basis of race, nationality, religion, or political opinion. They are not to be subjected to collective punishment or deportation. Pillage, reprisals, indiscriminate destruction of property, and the taking of hostages are prohibited. The safety, honor, family rights, religious practices, manners, and customs of civilians are to be respected.

All four Geneva Conventions contain an identical Article 3 applying to non-international conflicts. Under this article, those who have put down their arms or are out of the conflict due to injury or sickness must be treated humanely, without any adverse discrimination based on race, color, religion, sex, social status, or wealth, or any other such criteria. Specifically prohibited is “violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; ...outrages upon personal dignity, in particular humiliating and degrading treatment.”

Finally, the Conventions laid the groundwork for humanitarian relief during times of war by granting the ICRC special rights to carry out humanitarian activities on behalf of POWs. The ICRC or other impartial humanitarian relief organizations authorized by parties to the conflict must be permitted to visit with prisoners privately, examine conditions of confinement to ensure the Conventions’ standards are being met, and distribute relief supplies.

Human Rights Law Regarding Torture

Torture or inhuman treatment of prisoners-of-war or protected persons are grave breaches of the Geneva Conventions, and are considered war crimes. War crimes create an obligation on any state to prosecute the alleged perpetrators or turn them over to another state for prosecution. This obligation applies regardless of the nationality of the perpetrator, the nationality of the victim or the place where the act of torture or inhuman treatment was committed. Even persons who are not entitled to the protections of the 1949 Geneva Conventions (such as some detainees from third-world countries) are protected by the “fundamental guarantees” of article 75 of Protocol I of 1977 to the Geneva Conventions. Torture and other mistreatment of persons in custody are also prohibited in all circumstances under international human rights law, which applies in both peacetime and wartime.

Among the relevant treaties are the International Covenant on Civil and Political Rights (1976) and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984), both of which the United States has ratified. The standard definition of torture can be found in Article 1 of the Convention against Torture:

For the purposes of this Convention, the term "torture" means 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.

Prohibitions on torture and other ill-treatment are also found in other international documents, such as the Universal Declaration of Human Rights (1948), the U.N. Standard Minimum Rules for the Treatment of Prisoners (1977), and the U.N. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988).

Additionally, the prohibition on torture is considered a fundamental principle of customary international law that is binding on all states (what is known as a “peremptory norm” of international law because it preempts all other customary laws). All states are bound to respect the prohibition on torture and ill-treatment whether or not they are parties to treaties which expressly contain the prohibition. They are also obliged to prevent and to punish acts of torture, even if they are not parties to treaties that expressly require them to do so.

U.S. Law on Torture

The United States has long considered Article 75 of Protocol 1 of the Geneva Conventions to be part of customary international law. Article 75 prohibits murder, “torture of all kinds, whether physical or mental,” “corporal punishment,” and “outrages upon personal dignity, in particular humiliating and degrading treatment, ... and any form of indecent assault.”

In its Reservations to the Convention Against Torture, the United States professes to be bound by the obligation to prevent “cruel, inhuman or degrading treatment or punishment” only insofar as the term means the cruel, unusual and inhumane treatment or punishment prohibited by the Fifth, Eighth, and Fourteenth Amendments to the U.S. Constitution. Furthermore, U.S. reservations say that mental pain or suffering only refers to prolonged mental harm from: (1) the intentional infliction or threatened infliction of

severe physical pain or suffering; (2) the use or threat of mind altering substances; (3) the threat of imminent death; or (4) that another person will imminently be subjected to the above mistreatment.

The United States has incorporated international prohibitions against torture and mistreatment of persons in custody into its domestic law. The United States has reported to the Committee Against Torture that: “Every act of torture within the meaning of the Convention is illegal under existing federal and state law, and any individual who commits such an act is subject to penal sanctions as specified in criminal statutes. Such prosecutions do in fact occur in appropriate circumstances. Torture cannot be justified by exceptional circumstances; nor can it be excused on the basis of an order from a superior officer.”

A *federal anti-torture statute* (18 U.S.C. § 2340A), enacted in 1994, provides for the prosecution of a U.S. national or anyone present in the United States who, while outside the U.S., commits or attempts to commit torture. Torture is defined as an “act committed by a person acting under the color 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.” A person found guilty under the act can be incarcerated for up to 20 years or receive the death penalty if the torture results in the victim’s death.

Military personnel who mistreat prisoners can be prosecuted by a court-martial under various provisions of the *Uniform Code of Military Justice*. The *War Crimes Act of 1996* makes it a criminal offense for U.S. military personnel and U.S. nationals to commit war crimes as specified in the 1949 Geneva Conventions. War crimes under the Act include grave breaches of the Geneva Conventions. It also includes violations of common Article 3 to the Geneva Conventions. The law applies if either the victim or the perpetrator is a national of the United States or a member of the U.S. armed forces. The penalty may be life imprisonment or death. The death penalty is only invoked if the conduct resulted in the death of one or more victims.

The Department of Defense *Law of War Manual of 2015*, states that “The United States is a Party to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Convention against Torture was not intended to supersede the prohibitions against torture already contained in customary international law and the 1949 Geneva Conventions or its Additional Protocols. The law of war is the controlling body of law with respect to the conduct of hostilities and the protection of war victims. Nevertheless, a time of war does not suspend operation of the Convention Against Torture. The Convention Against Torture continues to apply even when a State is engaged in armed conflict. For example, a state of war could not justify a State’s torture of individuals during armed conflict. In addition, where the text of the Convention Against Torture provides that obligations apply to a State Party in ‘any territory under its jurisdiction,’ such obligations, including the obligations in Articles 2 and 16 to prevent torture and cruel, inhuman, or degrading treatment or punishment, extend to certain areas beyond the sovereign territory of the State Party, and more specifically to ‘all places that

the State Party controls as a governmental authority.””

ETHICAL CONSIDERATIONS

Despite the fact that health professional ethics have long stressed the need for loyalty to people in their care, health professionals are increasingly asked to weigh their devotion to patients against service to the objectives of government or other third parties. This problem of *dual loyalty* continues to challenge health professionals. Dual loyalty poses particular challenges for health professionals when the subordination of the patient's interests to state or other purposes risks violating the patient's human rights. Efforts to bolster ethical codes to address these challenges have only marginally succeeded.

Ethical codes relevant to medical professionals have been established by several processes. First, general theories of professional obligation have been derived from first principles by moral philosophers such as Immanuel Kant, wherein human beings, by virtue of having reason and self-awareness must be treated as ends in themselves, and not as a means to achieving any goal. (Heubel & Biller Andorno, 2005) Second, professional organizations such as the American Medical Association and the American Psychological Association have written and disseminated documents describing ethical principles. Third, international treaties developed by bodies such as the United Nations have been signed and ratified by national governments in attempts to codify accepted conduct and guide public policy. (United Nations, 1982)

Medical practitioners have acknowledged moral principles guiding their interactions with patients since antiquity, and the presence of similar moral frameworks in diverse cultures is a testament to their universality. *Charaka Samhita*, an ancient treatise of Ayurvedic medicine dating from the fourth Century B.C., states “Thou shall not desert or injure thy patient for the sake of thy life or thy living.” (Valiathan, 2003). The writings of ancient Greek physicians Hippocrates (Fourth Century B.C.) and Galen (Second Century A.D.), called upon physicians to commit to employing their skills for the benefit of patients and avoidance of harm. As noted in the original translation of the Hippocratic Oath:

“I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug nor give advice which may cause his death.”

The *Prayer of Maimonides*, translated from a 12th Century Hebrew manuscript, pledges help and support for all patients, including “enemy as well as friend (Friedenwald, 1918).” Islamic codes or medical ethics were articulated in the ninth century A.D. by Ishaq ibn Ali al-Ruhawi, in the text *Practical Ethics of the Physician*, and were adopted by the contemporary Muslim medical establishment in the 1981 Declaration of Kuwait. This document, entitled the *Islamic Code of Medical Ethics*, contained a chapter devoted to physicians' duties in wartime, which prohibited medical

professionals from permitting their resources to be used to inflict physical or psychological harm, regardless of political or military considerations. (Padella, 2007)

The *Declaration of Geneva (1949)* was intended to update the Oath of Hippocrates. In this declaration, the physician promised to “maintain the utmost respect for human life,” and to “not use my medical knowledge to violate human rights and civil liberties, even under threat”.

In October of 1949 the 3rd General Assembly of the World Medical Association adopted the *International Code of Medical Ethics* (amended 2006). In this document, a physician promises to: 1) respect a competent patient's right to accept or refuse treatment; 2) bear in mind the obligation to respect human life; 3) act in the patient's best interest when providing medical care; 4) owe his/her patients complete loyalty and all the scientific resources available to him/her; 5) respect a patient's right to confidentiality; and 6) not use “medical knowledge to violate human rights and civil liberties, even under threat”.

“Benefit' and 'harm'. Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or primum non nocere. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimizing damage to health, but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.”(2, 4)

The *Declaration of Tokyo: Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* (29th World Medical Assembly 1975) provides for the following:

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities.

- The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.
4. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.
 5. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner. (This has been superceded by the Declaration of Malta, outlined below)

World Medical Association Declaration of Malta on Hunger Strikers (Adopted 1991, editorially revised 1992, revised 2006) provides the following:

The guidelines are as follows:

“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. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting”

The principles are as follows:

1. Duty to act ethically. All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy. Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.
2. Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made involuntarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

3. 'Benefit' and 'harm'. Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or *primum non nocere*. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimizing damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.
4. Balancing dual loyalties. Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients. Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient.
5. Clinical independence. Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.
6. Confidentiality. The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously harms others. As with other patients, hunger strikers' confidentiality should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm. If individuals agree, their relatives and legal advisers should be kept informed of the situation.
7. Gaining trust. Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimizes harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.

The *United Nation's Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1982)* is as follows:

1. Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

2. It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.
3. It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.
4. It is a contravention of medical ethics for health personnel, particularly physicians:
 - a. To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments;
 - b. To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.
5. It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

Finally, several U.S. physician professional organizations have put forth **strong** ethical guidelines addressing the physician's role in torture and in interrogation. Most prominent have been those of the American College of Physicians, the American Medical Association, and the American Psychological Association.

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American Medical Association 2016 Code of Medical Ethics

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APPENDIX

The **ACP Ethics Manual, Sixth Edition**, adopted July 2011, states the following:

Relation of the Physician to Government

Physicians must not be a party to and must speak out against torture or other abuses of human rights. Participation by physicians in the execution of prisoners except to certify death is unethical. Under no circumstances is it ethical for a physician to be used as an instrument of government to weaken the physical or mental resistance of a human being, nor should a physician participate in or tolerate cruel or unusual punishment or disciplinary activities beyond those permitted by the United Nations' Standard Minimum Rules for the Treatment of Prisoners. Physicians must not conduct, participate in, monitor, or be present at interrogations (defined as a systematic effort to procure information useful to the purposes of the interrogator by direct questioning of a person under the control of the questioner; it is distinct from questioning to assess the medical condition or mental status of an individual) or participate in developing or evaluating interrogation strategies or techniques. A physician who becomes aware of abusive or coercive practices has a duty to report those practices to the appropriate authorities and advocate for necessary medical care. Exploiting, sharing, or using medical information from any source for interrogation purposes is unethical.

Limited access to health care is one of the most important characteristics of correctional systems in the United States. Physicians who treat prisoners as patients face special challenges in balancing the best interests of the patient with those of the correctional system. Despite these limitations, physicians should advocate for timely treatment and make independent medical judgments about what constitutes appropriate care for individual inmates.

The **AMA Code of Medical Ethics, 2016**, states the following:

Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment.

Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened.

Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue.

Physicians who treat torture victims should not be persecuted.

Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great.

The AMA issued *Opinion 2.068* in 2006 regarding physician participation in interrogations. That was subsequently revised and included in the *AMA 2016 Code of Medical Ethics*, Section 9.7.4, stating the following:

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations of criminal suspects, prisoners of war, or any other individuals who are being held involuntarily (“detainees”) are distinct from questioning used by physicians to assess an individual’s physical or mental condition. To be appropriate, interrogations must avoid the use of coercion—that is, threatening or causing harm through physical injury or mental suffering.

Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics. Questions about the propriety of physician participation in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to individuals with obligations to protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest.

Applying this general approach, physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

- (a) Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient’s participation in an interrogation.
- (b) Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician’s role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.
- (c) Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.
- (d) Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.

When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegation.

The **American Psychological Association** adopted the following comprehensive resolution in August 2007, amended in February 2008:

Reaffirmation of the American Psychological Association Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined in the United States Code as "Enemy Combatants"

Whereas the mission of the American Psychological Association is to advance psychology as a science and profession and as a means of promoting health, education and human welfare through the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association;

Whereas the American Psychological Association is an accredited non-governmental organization at the United Nations and so is committed to promote and protect human rights in accordance with the United Nations Charter and the Universal Declaration of Human Rights;

Whereas the American Psychological Association passed the 2006 Resolution Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, a comprehensive and foundational position applicable to all individuals, in all settings and in all contexts without exception;

Whereas in 2006, the American Psychological Association defined torture in accordance with Article I of the United Nations Declaration and Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, [T]he term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted upon 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 [e.g., governmental, religious, political, organizational] capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions [in accordance with both domestic and international law];

Whereas in 2006, the American Psychological Association defined the term "cruel, inhuman, or degrading treatment or punishment" to mean treatment or punishment by a psychologist that, in accordance with the McCain Amendment, is of a kind that would be "prohibited by the Fifth, Eighth, and Fourteenth Amendments to the Constitution of the United States, as defined in the United States Reservations, Declarations and Understandings to the United Nations Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment done at New York, December 10, 1984." Specifically, United States Reservation I.1 of the Reservations, Declarations and Understandings to the United Nations Convention Against Torture stating, "the term

'cruel, inhuman or degrading treatment or punishment' means the cruel, unusual and inhumane treatment or punishment prohibited by the Fifth, Eighth, and/or Fourteenth Amendments to the Constitution of the United States."ii

Be it resolved that the American Psychological Association reaffirms unequivocally the 2006 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment in its entirety in both substance and content (see Appendix A);

Be it resolved that the American Psychological Association affirms that there are no exceptional circumstances whatsoever, whether induced by a state of war or threat of war, internal political instability or any other public emergency, that may be invoked as a justification for torture or cruel, inhuman, or degrading treatment or punishment, including the invocation of laws, regulations, or orders;

Be it resolved that the American Psychological Association unequivocally condemns torture and cruel, inhuman, or degrading treatment or punishment, under any and all conditions, including detention and interrogations of both lawful and unlawful enemy combatants as defined by the US Military Commissions Act of 2006;

Be it resolved that the unequivocal condemnation includes an absolute prohibition against psychologists' knowingly planning, designing, and assisting in the use of torture and any form of cruel, inhuman or degrading treatment or punishment;

Be it resolved that this unequivocal condemnation includes all techniques considered torture or cruel, inhuman or degrading treatment or punishment under the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; the Geneva Conventions; the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; the Basic Principles for the Treatment of Prisoners; or the World Medical Association Declaration of Tokyo. An absolute prohibition against the following techniques therefore arises from, is understood in the context of, and is interpreted according to these texts: mock executions; water-boarding or any other form of simulated drowning or suffocation; sexual humiliation; rape; cultural or religious humiliation; exploitation of fears, phobias or psychopathology; induced hypothermia; the use of psychotropic drugs or mind-altering substances; hooding; forced nakedness; stress positions; the use of dogs to threaten or intimidate; physical assault including slapping or shaking; exposure to extreme heat or cold; threats of harm or death; isolation; sensory deprivation and over-stimulation; sleep deprivation; or the threatened use of any of the above techniques to an individual or to members of an individual's family. Psychologists are absolutely prohibited from knowingly planning, designing, participating in or assisting in the use of all condemned techniques at any time and may not enlist others to employ these techniques in order to circumvent this resolution's prohibition;

Be it resolved that the American Psychological Association calls on the United States government--including Congress, the Department of Defense, and the Central

Intelligence Agency--to prohibit the use of these methods in all interrogations and that the American Psychological Association shall inform relevant parties with the United States government that psychologists are prohibited from participating in such methods ;

Be it resolved that the American Psychological Association, in recognizing that torture and other cruel, inhuman or degrading treatment and punishment can result not only from the behavior of individuals, but also from the conditions of confinement, expresses grave concern over settings in which detainees are deprived of adequate protection of their human rights, affirms the prerogative of psychologists to refuse to work in such settings, and will explore ways to support psychologists who refuse to work in such settings or who refuse to obey orders that constitute torture;

Be it resolved that the American Psychological Association asserts that any APA member with knowledge that a psychologist, whether an APA member or non-member, has engaged in torture or cruel, inhuman, or degrading treatment or punishment, including the specific behaviors listed above, has an ethical responsibility to abide by Ethical Standard 1.05, Reporting Ethical Violations, in the *Ethical Principles of Psychologists and Code of Conduct* (2002) and directs the Ethics Committee to take appropriate action based upon such information, and encourages psychologists who are not APA members also to adhere to Ethical Standard 1.05;

Be it resolved that the American Psychological Association commends those psychologists who have taken clear and unequivocal stands against torture and cruel, inhuman or degrading treatment or punishment, especially in the line of duty, and including stands against the specific behaviors (in lines 81 through 100) or conditions listed above; and that the American Psychological Association affirms the prerogative of psychologists under the *Ethical Principles of Psychologists and Code of Conduct* (2002) to disobey law, regulations or orders when they conflict with ethics ;

Be it resolved that the American Psychological Association asserts that all psychologists with information relevant to the use of any method of interrogation constituting torture or cruel, inhuman, or degrading treatment or punishment have an ethical responsibility to inform their superiors of such knowledge, to inform the relevant office of inspector generals when appropriate, and to cooperate fully with all oversight activities, including hearings by the United States Congress and all branches of the United States government, to examine the perpetration of torture and cruel, inhuman, or degrading treatment or punishment against individuals in United States custody, for the purpose of ensuring that no individual in the custody of the United States is subjected to torture or cruel, inhuman, or degrading treatment or punishment;

Be it resolved that the APA Ethics Committee shall proceed forthwith in writing a casebook and commentary that shall set forth guidelines for psychologists that are consistent with international human rights instruments, as well as guidelines developed for health professionals, including but not limited to: Common Article 3 of the Geneva Conventions; The United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; The United Nations Principles of Medical Ethics

Relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; and The World Medical Association Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment;

Be it resolved that the American Psychological Association, in order to protect against torture and cruel, inhuman, or degrading treatment or punishment, and in order to mitigate against the likelihood that unreliable and/or inaccurate information is entered into legal proceedings, calls upon United States legal systems to reject testimony that results from torture or cruel, inhuman, or degrading treatment or punishment. Defined as both unlawful enemy combatants and lawful enemy combatants as set forth in the U.S. Military Commissions Act of 2006 (Chapter 47A; Subchapter I: § 948a. Definitions)

(1) Unlawful enemy combatant —

A) The term "unlawful enemy combatant" means —

(i) a person who has engaged in hostilities or who has purposefully and materially supported hostilities against the United States or its co-belligerents who is not a lawful enemy combatant (including a person who is part of the Taliban, al Qaeda, or associated forces); or (ii) a person who, before, on, or after the date of the enactment of the Military Commissions Act of 2006, has been determined to be an unlawful enemy combatant by a Combatant Status Review Tribunal or another competent tribunal established under the authority of the President or the Secretary of Defense.

(B) Co-belligerent — In this paragraph, the term "co-belligerent", with respect to the United States, means any State or armed force joining and directly engaged with the United States in hostilities or directly supporting hostilities against a common enemy.

(2) Lawful enemy combatant — The term "lawful enemy combatant" means a person who is—

(A) a member of the regular forces of a State party engaged in hostilities against the United States;

(B) a member of a militia, volunteer corps, or organized resistance movement belonging to a State party engaged in such hostilities, which are under responsible command, wear a fixed distinctive sign recognizable at a distance, carry their arms openly, and abide by the law of war; or

(C) a member of a regular armed force who professes allegiance to a government engaged in such hostilities, but not recognized by the United States.

Amendment V

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived

of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Amendment VIII

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

Amendment XIV

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

The APA Ethics Committee issued the following statement, “No Defense to Torture under the APA Ethics Code,” in June 2009, amended in November 2015:

Torture in any form, at any time, in any place, and for any reason, is unethical for psychologists and wholly inconsistent with membership in the American Psychological Association.

No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, legal compulsion or organizational demand, may be invoked as a justification for torture.

There is no defense to torture under the *Ethical Principles of Psychologists and Code of Conduct* (2002, as amended 2010).

The APA Ethics Committee will not accept any defense to torture in its adjudication of ethics complaints.

The **American Nurses Association** Position Paper, *The Nurse’s Role in Ethics and Human Rights: Protecting and Promoting Individual Worth, Dignity, and Human Rights in Practice Settings*, from February 2016, states the following:

Purpose

Nurses must always stress human rights protection and uphold the values and ethics of the profession. The purpose of this position statement is to bring the topic of human rights to the forefront and provide nurses with specific actions to protect and promote human rights in every practice setting. It describes the relationship between nurses’ ethical obligations, the concept of human rights, and professional nursing practice.

Statement of ANA Position

The American Nurses Association believes that respect for the inherent dignity, worth, unique attributes, and human rights of all individuals is a fundamental principle (“Code of Ethics for Nurses with Interpretative Statements” [American Nurses Association, 2015, p. 1]). Nurses establish relationships of trust and provide nursing services according to need, setting aside any bias or prejudice (ANA, 2015, p. 1). This statement on ethics and human rights provides the foundation and context for all other position statements related to the practice of nursing. The protection and promotion of human rights in health and health care are fundamental functions of the American Nurses Association.

Recommendations

ANA supports the following recommendations:

- All nurses advocate for human rights of patients, colleagues, and communities. 8515 Georgia Avenue, Suite 400 Silver Spring, MD 20910 www.nursingworld.org Page
- Nurses advocate for the ethical and just practice of nursing by creating and sustaining environments that support accepted standards of professional practice, since the practice environment and rights of nurses influence the practice and moral context of nursing.
- Nurses strengthen practice environments by refusing to practice in ways that would create a negative impact on the quality of care.
- Through their professional organization, nurses must reaffirm and strengthen nursing values and ideals with a united voice that interprets and explains the place and role of nursing in society (ANA, 2015).
- Health care agencies pay close attention to potential for human rights violations as they relate to patients, nurses, health care workers, and others within their institutions.
- Health care agencies support policies and practices that actively maintain environments ensuring ethical nursing practice, upholding human rights and methods for reporting violations, and taking action to prevent recurrence.
- Nurses in every practice setting serve on ethics committees, work to promote the discussion of ethics and human rights among colleagues, and engage in political action to clarify and promote health policy that increases access to and equality of care.
- Nurses must examine the conflicts arising between their own personal and professional values and the values and interests of others who are also responsible for patient care and health care decisions, and they must address these conflicts in ways that ensure patient safety and promote the best interests of the patient (ANA, 2015).
- Nurses work collaboratively within the profession and with other health care professionals to create moral communities that promote, protect, and sustain ethical practice and the human rights of all patients and professional constituents (ANA, 2010).
- Nurse educators embrace the concepts of justice and caring as guiding principles in teaching students about ethics and human rights within the provision of health care everywhere — from local communities to the greater global community.
- Nurse educators must firmly anchor students in nursing professional responsibility to address unjust systems and structures, modeling the profession’s commitment to social justice and health through content, clinical and field experiences, and critical thought (ANA, 2015).

- Nurse researchers ensure that human rights are fulfilled through the process of ongoing informed consent, continual assessment of risk versus benefit for research participants, and the prevention of harm.
- Nurse researchers conduct research that is relevant to communities of interest, are guided by participation of these communities in identifying research problems, and strive to benefit patients, society, and professional practice.
- Nurse administrators incorporate ethics and human rights principles into practice by monitoring the practice environment for actual or potential human rights violations of patients, nurses, and other workers in the health care environment.
- Nurse administrators assess policy and practice and identify risks for reduced quality of care that may occur as a result of unacknowledged violations of human rights.
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- Nurse administrators actively promote a caring, just, inclusive, and collaborative environment in their organizations and beyond to their communities.

Background

The Universality of Human Rights

The current articulation and modern interpretation of human rights emerged from the Universal Declaration of Human Rights adopted by the United Nations General Assembly in 1948. Article 25 has specific importance for those in health care. It states in part that every person has the right to a standard of living adequate for the health and well-being of his or her family, including food, clothing, housing, and medical care (UN, 1948). Ssenyonjo (2013) notes that “the UDHR has established itself as an instrument of significant moral and legal influence universally” (p.13).

Human Rights and the Code of Ethics for Nurses

Benatar (2003) suggests that we must go “beyond the rhetoric of universal human rights to include attention to duties, social justice and interdependence” (p.108). The code addresses attention to duty, social justice, and interdependence in Provision 4, “Nurses bear primary responsibility for the nursing care that their patients and clients receive and are accountable for their own practice ...” (ANA, 2015, p.15), and Provision 8, “The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy and reduce health disparities” (ANA, 2015, p.31). Nurses advocate for equity and social justice in resource allocation, access to health care, and other social and economic services” (International Council of Nurses, 2012).

Human Rights and Health

The ICN also addresses the nurse’s four universal and fundamental responsibilities to promote health, to prevent illness, to restore health, and to alleviate suffering (ICN, 2012). “Inherent in nursing is a respect for human rights, cultural rights, the right to life and choice, and dignity, and to be treated with respect” (ICN, 2012). The ICN position statement on nurses and human rights is consistent with Article 25 of the UDHR when it states that the ICN “views health care as a right of all individuals ... including the right to choose or decline care, the right to accept or refuse treatment or nourishment ... and the right to die with dignity” (ICN, 2011, p.1).

Ethical Obligation and the Just Provision of Care

Where there are rights, there are also obligations to fulfill claims to rights. For example, the right to fair and equal treatment in health care requires that nurses provide fair and equal treatment to all patients. Nurses are obligated by the code to provide fair and equal treatment that respects the “inherent dignity, worth and unique attributes of every person ... regardless of the factors contributing to the person’s health status” (ANA, 2015, p.1). “The worth of a person is not affected by illness, ability, socioeconomic status, functional status or proximity to death” (ANA, 2015, p.1). Further, the just provision of care requires that these factors be considered, as they influence the need for care and the allocation of health care resources. Claim rights, or rights that are due to the rightholder by another, are fulfilled when health care policies are developed that require individual and group differences to be considered in the delivery of care to fulfill patients’ health care needs (U.S. Department of Health & Human Services, 2010).

Health care that is congruent with the patient’s needs and with available resources can be said to be both just and caring. Such care is aimed at reducing the unfair burden of illness, suffering, and premature death of vulnerable populations resulting from social inequities and institutionalized patterns of social discrimination. 8515 Georgia Avenue, Suite 400 Silver Spring, MD 20910 www.nursingworld.org (p.4)

Advocacy in Health Care Settings

Ethics and human rights issues emerge in health care settings when individuals are unable to assert their rights. Individuals in critical care units or psychiatric settings, or individuals who are incarcerated, might have diminished capacity for decision-making and asserting their rights. This is also true of children or individuals who are not considered to be competent in the legal sense (Committee on Bioethics, 2006; Hendrick, 2010). It is in these circumstances that human rights are vulnerable to violation and that ethical issues will emerge. Refusal to provide reasonable and necessary care also violates a patient’s human rights when he or she has a just claim to care. Examples of this would be ignoring the complaints of a patient based on a personal characteristic such as ethnicity or a situational one such as being incarcerated. Such examples not only violate ethical standards of nursing, but they also are not congruent with a relational model of human caring that provides the framework for nursing. Nurses must be fully aware of patients’ rights for all settings, ages, and developmental abilities, and they must be willing to advocate for them and to collaborate with others in finding solutions to ethical issues.

History/Previous Position Statements

This statement updates and supersedes the ANA position statement “Ethics and Human Rights” of June 14, 2010, originated by the Center for Ethics and Human Rights and adopted by the ANA Board of Directors (ANA, 2010). The primary drivers for the original statement in 1991 were the nursing shortage, the increased focus on the need for informed consent for research participants, lack of access to health care, and media focus on whistleblowing. That original statement had proven valuable for nurses as they confronted unsafe staffing conditions and expanded roles in research. Ten years later, an updated version of the “Code of Ethics for Nurses” was published (ANA, 2001). It

included multiple approaches to ethics that were relevant for nurses, broadening global health concerns, diverse practice settings, and increasingly complex roles. A revised position statement on the nurse's role in ethics and human rights (ANA, 2010) was created due to a greater awareness of the changes in health care and its emerging societal context. In 2015, the "Code of Ethics for Nurses with Interpretive Statements" was updated (ANA, 2015), providing a current statement of ethical values, obligations, duties, and professional ideals for the evolving nursing profession and societal context. Clearly articulated ethical positions, astute understanding of human rights, careful discernment of human rights violations, and bold acceptance of professional responsibility converged to provide a backdrop for all nursing practice.

Supportive Material

Ethics and human rights have previously been discussed in the "Code of Ethics for Nurses with Interpretive Statements" (ANA, 1985, 2001, 2015), the ANA "Ethics and Human Rights" position statement (1991, 2010), "Public Health Nursing: Scope and Standards of Practice" (ANA, 2007, 2013), "Nursing Administration: Scope and Standards of Practice" (ANA, 2015), and "Nursing's Social Policy Statement" (ANA, 2003, 2010). These documents delineate and uphold the role of the nurse in promoting and maintaining ethical practice through the preservation of human rights. Evident in these documents is the progression of how ethics and human rights are conceptualized as going beyond the individual patient's rights to the rights of the nurse, vulnerable populations, health care colleagues, and the global community.

Summary

This statement on ethics and human rights provides the foundation and context for all other position statements related to the practice of nursing. The protection and promotion of human rights related to health and health care are fundamental functions of ANA. 8515 Georgia Avenue, Suite 400 Silver Spring, MD 2010 www.nursingworld.org (p.5)

Ethics, human rights, and nursing interface within professional practice in the context of human relationships. In a caring context, nurses advocate for patients' rights, especially for those whose rights may be more easily violated or not fulfilled. The human rights of self, patients, colleagues, and both local and global communities are of concern to nurses. This requires action designed to ensure that they are protected and promoted. Without exception, all nursing practice in all settings is grounded in respect for the inherent dignity, worth, unique attributes, and human rights of all individuals (ANA, 2015). One of the purposes of ANA is to recognize and work with other organizations that have similar missions and philosophies. This document also identifies various organizations, with their web addresses, that have as their purpose the protection of human rights. (See the appendix that follows the list of references.) These resources will be useful to nurses as advocates for human rights and ethical standards of nursing practice.