

From the Personal to the Political: The involvement of Israeli physicians in the torture and ill-treatment of detainees

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Today, I want to speak about the involvement of physicians in Israel in the torture and ill-treatment of Palestinians incarcerated in detention facilities. I would like to focus on the individual, social and political mechanisms that make this sort of conduct by physicians possible.

The issue of medical personnel being involved in torture is not exclusive to the Israeli-Palestinian conflict, but is a worldwide phenomenon. Many physicians working under various oppressive regimes, in different times and countries, have collaborated with the regime in various ways, instead of siding with its critics. Treaties and declarations against torture that aim to protect human rights are extremely valuable and necessary, but they are insufficient. Too many national medical associations are satisfied with signing the relevant treaties and declarations, without actually implementing them.

The involvement of both individual medical professionals and the medical system in the torture and ill-treatment of detainees has a long history. Medical professionals hold in their hands the power-knowledge of healing and curing body and soul, but that same power-knowledge can also be used to cause harm. The medical system functions as an agent of social oversight, regulation and control. It also determines social norms as society gives health professionals the power to judge and punish. Hence, for example, physicians determine a person's fitness to work, fitness to stand

trial, and the fitness of a patient to decide on the medical treatment that will or will not be administered to him or her. Physicians possess the power to determine how we enter this world and how we depart it.

Israel Prison Service physicians provide medical authorization for the solitary confinement and isolation of prisoners. Psychiatrists, who until recently gave their medical opinions to the courts via "isolation committees," have brought about the continued incarceration of detainees in solitary confinement, causing unequivocal, and sometimes irreversible, harm to their health.

The medical caregiver, in a blindness that serves parts of his subjectivity, perceives only a part of the object (the patient), yet considers it to be the whole. The object is thus seen as nothing more than a "criminal," an "Arab," a "terrorist," a "woman."

The decisions of these physicians are often influenced by extraneous considerations that undermine their commitment to act, first and foremost, for the benefit of the patient, as required by the rules of medical ethics.

Physicians for Human Rights – Israel (PHR-I) view human rights and their protection as an inseparable, fundamental and distinct part of the medical profession. The question of where the medical profession positions itself between the state and the individual is a social-political question that is contingent both on the self-awareness of those who work in the medical field, and on their understanding of the role of healthcare

professionals as protectors of human rights. I will discuss how medical professionals in Israel abuse the vast powers they wield.

Torturers, physicians, and the tortured

Physicians in Israel are involved in the torture and ill-treatment of detainees and prisoners, and particularly of incarcerated Palestinians, in the following ways:

- By disregarding complaints of torture or ill-treatment.
- By failing to prevent the return of detainees/patients to the location where torture or ill-treatment took place.
- By failing to document past or current complaints of torture or ill-treatment made by detainees/patients.
- By failing to report suspicions that torture or ill-treatment is taking place or has taken place.
- By passing confidential medical information about patients to interrogators suspected of employing methods that are regarded as torture or ill-treatment.
- By providing medical authorization, directly or indirectly, for practices that are harmful to a person's health.

The critical question is what causes someone who studied the profession of healing,

the very foundation of which is to benefit mankind, to ignore and not protest against harm caused to a patient under his or her care, or – even worse – to be a complicit partner in inflicting this harm on behalf of an organization or a state?

Detainees and prisoners comprise a vulnerable population. Their rights are violated in many respects, including with regard to the medical care and treatment that is provided to them by physicians. Furthermore, when detainees are members of a cultural and national group that is different from that of the medical caregivers, this difference may significantly affect the quality of the diagnosis and care they receive. The reason is that, whether consciously or unconsciously, the medical professional brings into the interaction of diagnosis or treatment his or her own view of social-political reality, which contributes significantly to the way in which he or she understands the patient and interprets his or her complaints. In too many cases, this interaction entails the diminution of the humanity of the patient – the detainee/prisoner – in accordance with the subjective psychological needs of the physician. One can argue that the doctor reduces the patient to a single aspect of the qualities attributed to him or her.

The medical caregiver, in a blindness that serves parts of his subjectivity, perceives only a part of the object (the patient), yet considers it to be the whole. The object is thus seen as nothing more than a “criminal,” an “Arab,” a “terrorist,” a “woman.” This view eliminates the object’s individuality and transforms him into nothing more than the representative of a group with stereotypical characteristics, which stem from the physician’s prejudices. It happens both inside and outside the prison.

The loss of the social and political dimension

Psychiatry has classically positioned itself in the intra-personal dimension. During the latter decades of the twentieth century, the inter-personal dimension was added to the field. From the perspective of classical psychiatry – according to which everything occurs in the intrapersonal dimension – the social-political dimension has been rejected from the confines of its discourse, disregarding the fact that the exclusion of this dimension is, in and of itself, a political stance. However, there is indeed legitimate scope within psychiatry for this social-political dimension in addition to the interpersonal and intrapersonal dimensions, as a supra-personal dimension, one that goes beyond the personal. The inclusion of the social-political dimension in the discourse of psychiatry serves to introduce what has been missing from psychiatry for such a long period of time: the awareness and theoretical tools needed to both conceptualize a person as a social-political being and recognize human rights as a vital part of it.

These elements – human rights and an inclusive concept of the person – should be integral components of all branches of medicine if we are to implement the rules of medical ethics.

The therapist-physician must be aware of his or her own subjectivity, recognize that it is always present, and not fall back on the classic theory, which supposedly equips him or her with objectivity and neutrality. This will give the patient a chance to stand alongside the caregiver, not automatically opposite him. The patient will then cease to be an "object", which implies "standing opposite", and which in turn carries connotations of enmity and a state of war. Thus, the time-honored concept of the therapist as an objective and neutral person who stands opposite the patient is undermined.

However, this advice cannot apply when the therapist is in no way interested in looking inwards at his or her personal-social-cultural-political perspective, or at his or her own concerns. In this case the therapist may prefer "*outsight*" to insight. Within the political power game that the state plays in order to silence and repress the Other, physicians can have a blind spot when it comes to recognizing the extent of their own cooperation with it. This blind spot allows physicians to disregard their professional-ethical role to protect the rights of the patient, the detainee, the Other, defined as anyone whom the social order consciously silences. "*Outsight*" is a system of ideas and viewpoints that come from the outside – in this case from the social systems of the ruling power. This specific blindness allows physicians to regard themselves as "apolitical" and to view anyone who opposes or does not identify with the regime's point of view as acting out of "political motives", which stand in opposition to the purity of the medical profession. This form of identification by the psychiatrist with the ruling power has been repeated many times in history. We are familiar with cases from the twentieth century, when the medical world served as an instrument of oppressive, despotic regimes, such as those in Germany, the Soviet Union, Argentina, Chile, the USA and others.

It is fundamentally important, both in theory and in practice, that physicians recognize that they are on the side of the forces that are in power in the given political-social-cultural reality: the healthy versus the ill, Israeli versus Palestinian, the free versus the imprisoned, the white collar person versus the convicted criminal, at times the educated person with means versus the uneducated person without, and often, despite the many recent advances, man versus woman.

From theory to practice: What happens when a Jewish-Israeli physician examines a Palestinian prisoner?

What is the physician's personal stance when the person he or she examines is not from his or her own culture or national group? And, in the context of Israel, what is the personal stance of the physician when he or she examines a Palestinian, who is not only a stranger but also perceived as an enemy? Is the medical system aware of its subjective biases, whereby it views the person under examination as a "terrorist" who poses a real security threat to the society? This perspective may be so all-encompassing that it obscures any other element of the patient's humanity.



The health system's role in protecting "public security" in certain circumstances (for example, in cases of danger to the public to incarcerate the patient, contagious illnesses that necessitate reporting, compulsory hospitalization, etc.) and the real power that comes with this may blur the boundaries between the system's political and professional stance. In the Israeli context the absence of sufficient awareness of the physician's personal stance means the Palestinian patient, in too many cases, is perceived as a terrorist and indeed as a threat to the public security rather than as a patient in need of medical care. This increases the likelihood that Palestinian detainees who complain of torture, ill-treatment or harmful detention conditions will not receive the appropriate treatment and protection from their doctor.

The case of J.M.

To underline what I just said, I would like to discuss a specific case. J.M. was arrested in 2008. After three months in detention and interrogation by the GSS (the Israeli General Security Services, Shin Bet, or Shabak), he was taken to a housing unit where he was brutally beaten until his head and face were bleeding and he felt that he was losing consciousness. A doctor examined him and told the interrogators that J.M. should be taken to a hospital. The interrogator in charge told everyone present (the two men who had beaten J.M., the doctor and the ambulance crew) not to talk about what had happened. If asked, they were to say that J.M. had fallen down some stairs. All present agreed to adhere to this version of events. In the public hospital to which J.M. was later taken, he was examined by three different doctors, each of whom refused to listen to his claims of being beaten. They all appeared to accept the story that he had fallen down stairs. One of them told J.M. that what happened to him was not her concern, that her role was merely to treat him, and that the cause of his injury was of no interest to her. After some three hours, stitches to the head and an X-ray, J.M. was released from hospital and returned to the interrogation center. There he met a doctor employed by the Israeli Prison Service, who again ignored his attempts to report the abuse, gave him pain killers, and allowed the security guards to escort him to a solitary confinement cell.

The recognition that we are all "tainted" by a political viewpoint makes it possible to open up a discourse within the medical profession that can develop insight among its members. Progressing in this direction will make it possible for the medical profession to protect human rights

On the basis of J.M.'s affidavit and the hospital's medical documentation, it is clear that all the doctors who examined him after the beating ignored his complaints and did not properly document them. They did not report the injuries and allowed J.M. to be returned to a setting where he may be tortured again.

Following the case of J.M., PHR-I contacted the hospital at which he was treated, the Ministry of Health, and the Israel Medical Association to request an investigation

into the involvement of various physicians in this case. PHR-I further requested that copies of the rules of medical ethics and obligations regarding the treatment and protection of imprisoned persons who are subjected to torture or ill-treatment be distributed to medical professionals, and that the Ministry of Health announce legal and financial support for medical professionals who report and bring an end to incidents of torture and ill-treatment in case they encounter mistreatment by their employers.

Furthermore, it is the position of PHR-I that doctors should not be employed by the IPS or the GSS, and that they should not work in GSS interrogation facilities.

In July 2011, following additional complaints by PHR-I against the involvement of medical teams in the torture and ill-treatment of imprisoned persons, and the publication of a report by the Public Committee against Torture in Israel (PCATI) and PHR-I¹, the Ministry of Health announced that it had appointed a "Committee for Medical Staff Reporting Harm to Interrogatees' Medical Condition." Unfortunately, questions addressed to the Ministry of Health regarding the staffing and function of the committee and how one should approach it have gone unanswered, giving us reason to fear it is not actually operating.

Conclusion: From the Personal to the Political

The fact that the medical establishment in Israel refrains from discussing the involvement of physicians and other medical personnel in the torture and ill-treatment of imprisoned persons testifies to a common political-social need of both many individual physicians and of the organization that binds them. This need is that of the Israeli-Zionist to view the Palestinian as an enemy, a terrorist, an agent of danger. It is so frequently expressed that it can be viewed as a coherent system; one that does not allow a Palestinian who is being tortured or ill-treated to transcend the sole role that has been assigned to him: a terrorist. This attitude has been adopted by junior as well as senior physicians, department heads and district physicians, new immigrants and people born in Israel, and inhabitants of the north, center and south of the country. They all live among their people. One should not assume, however, that physicians act out of malice for malice's sake or out of professional ignorance. The violation of human rights and the rights of the patient is not the goal; rather, the goal is to sustain a single, uniform image for all Palestinians – that of the enemy – which helps to preserve the social fiber of the Israeli Zionists as a coherent group with a common ideology and purpose. The presence of an enemy is vital to maintain both the affinity and the reciprocal relations between the patriotic-Zionist discourse

¹The Public Committee Against Torture in Israel and Physicians for Human Rights – Israel, *Doctoring the Evidence, Abandoning the Victim*, October 2011: http://www.phr.org.il/uploaded/Doctoring%20the%20Evidence%20Abandoning%20the%20Victim_November2011.pdf

and actions that derive from this discourse, which include the Occupation and the repression, arrest and torture of Palestinians.

Therefore, it is what the security forces portray as the political “crimes” of the patient – the Palestinian detainee – and not his or her medical condition, that too often determine the medical diagnosis and treatment that he or she receives. The detainee is seen as a terrorist, an enemy, a person who endangers the State of Israel, and threatens its citizens and soldiers; not as someone who has been hurt and needs a physician’s help and protection.

We at PHR-I are often accused by physicians and the medical establishment at large of taking a political stance, of being “too political.” We answer these claims with the words of Stephen Mitchell: “Is not the posture of not taking sides itself a partisan position, a side one is taking?”²

The problem is not one of “taking sides”. The problem is when we do not see that we are taking a side, because all of us take a side. The question is how aware we are, as physicians, that we, like anyone else, are subjective and political. When we take the side of the establishment, there is a tendency to blindness that fosters the comfortable thought that we are not political. Concurrence with the establishment, and avoiding casting doubts on its deeds, is perceived as an objective, not a political, attitude. And yet protesting these deeds is considered a political stance. Elucidating the blind spot is considered a one-sided, extreme act that vilifies one’s colleagues.

The recognition that we are all “tainted” by a political viewpoint makes it possible to open up a discourse within the medical profession that can develop insight among its members. Progressing in this direction will make it possible for the medical profession to protect human rights. By contrast, a lack of openness will result in a perversion of the power of medical professionals, and will necessarily lead to ongoing human rights violations.

² Stephen Mitchell, *Influence and Autonomy in Psychoanalysis*, 1997, London: Hillsdale, pp. 183.