

Harm Through Those Supposed To Heal: Exploring Harm as an Analytical Concept in Violence Research Through Cases of Medical Involvement in Torture from Syria

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Abstract

This article bases its findings on an extensive praxeological reconstruction of medical involvement in torture in Syria since 2011. The research was conducted from 2021–2023 by examining reports of human rights organisations and activists, the accounts of survivors as well as trial reports and academic literature. After outlining an inexhaustive list of prevalent patterns of medical involvement in torture compiled for the overall reconstruction of this practice, three prevalent patterns will be portrayed more closely.

These patterns suggest benefits and research-stimulating open questions resulting from exploratively employing *harm* as an analytical concept in violence research: (1.) Medical negligence and arbitrary treatment, (2.) anamnesis and the exploitation of medical history, and (3.) the broader pattern of transporting people to and detaining them in military hospitals.

This article supposes that employing harm as an analytical concept in violence research can free us from too narrow (legal) categories, allows us to look beyond over-simplified dichotomies of perpetrators and victims, enables us to discuss epistemic impacts of the practice, and further allows us to revisit definitions like the one of medical involvement in torture.

Keywords

medical involvement in torture, torture doctoring, Syrian prison system, military hospitals, harm as an analytical concept

I will soothe the pain of anyone who needs my art, and if I don't know how, I will seek the counsel of my teachers. I will offer those who suffer all my attention, my science and my love. Never will I betray them or risk their wellbeing to satisfy my vanity. I will not hurt my fellow or put a knife to his flesh if I don't know how, or give him an herb to soothe his pain, even if he begs for it in anguish, if it might take away his breath.

— From the Hippocratic Oath (Arenas, 2010, p. 111)

Introduction

Despite taking the Hippocratic oath when starting their medical career, the involvement of doctors in torture is not as scarce as this oath would suggest. Doctors' involvement in torture was first documented extensively in the Nuremberg trial in 1946, where 23 "physicians and scientists were

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accused of war crimes, committed on vulnerable populations and inmates of concentration camps between 1933 and 1945" (Lemaire, 2006, p. 2049) — such involvements have become a frequent pattern on a global scale (Teays, 2019, p. 26).

Steven Miles has shed some light on this practice and its scope:

Torturing societies routinely employ doctors and nurses to work in their prisons [...] Twenty to fifty percent of torture survivors report that they saw physicians serving as active accomplices during the abuse. That statistic does not include prisoners who never see the physician who falsifies medical records or death certificates so as to conceal torture. It does not count those who are victimized by techniques that doctors and psychologists devised for torturers to use. (Miles, 2009, p. 24)

With special respect to his work concerning the United States, he developed a definition according to which, a "torture doctor" (Miles, 2020, p. 51) is

A licensed physician who directly or indirectly puts (a) medical knowledge or skills or (b) the authorities, duties, or privileges conferred by the medical license in the service of "torture" or cruel, inhuman, or degrading treatment or punishment as such terms are understood in international law. (Miles, 2020, p. 51)

Based on this, he developed a taxonomy of torture doctoring (figure 1) categorising the various ways in which he considers doctors to be involved in torture.

| TABLE 4.1 Taxonomy of torture doctoring | |
|--|---|
| A. Misuse of medical knowledge or skills | <ol style="list-style-type: none"> 1. The physician inflicts torture. 2. The physician misuses medical knowledge or skills to abet torture by others. 3. The physician misuses medical skills while providing treatment. 4. The physician misuses medical knowledge and skills to clear prisoners as fit for torture. 5. The physician misuses medical knowledge or skills to monitor prisoners being tortured so that the torture may proceed. 6. Miscellaneous |
| B. Misuse of the authorities or duties conferred by a medical license | <ol style="list-style-type: none"> 1. The physician misuses the authority to acquire and release medical materials for the purpose of torture. 2. The physician fails to create accurate medical records in order to abet torture. 3. The physician fails to undertake the treatment of a tortured person in a manner that abets the abuse. 4. The physician fails to safeguard medical records for the tortured prisoners to use for their own interests. 5. The physician fails to report torture. 6. The physician abets abusive research on prisoners that violates established research standards. |

Figure 1. Taxonomy of Torture Doctoring according to Miles (2020, p. 50).

While the case of doctors' involvement in torture concerning the so-called *war on terror* by the United States has been extensively covered in academic literature, another recent example of medical involvement in torture has gone largely unnoticed. This article will therefore base its considerations on cases from Syria since 2011. All cases considered are reported cases of state violence on the part of the Syrian regime and affiliated forces and are used to reconstruct prevalent patterns. Thus, torture practices by other actors, for example by *Daesh*, were not included in the analysis.

This article bases its findings on an extensive praxeological reconstruction of medical involvement in torture in Syria since 2011. By examining reports of human rights activists and organisations like the Syrian Network for Human Rights (SNHR), the accounts of survivors, as well as trial reports from the Syria Justice and Accountability Centre (SJAC) and academic literature, and after outlining an inexhaustive list of prevalent patterns of medical involvement in torture compiled for the overall reconstruction of this practice, three core patterns will be portrayed more closely.

After providing a short insight into the context of the case at hand and preliminarily defining the term *medical involvement in torture* for this article, these three patterns *should* help in discussing the benefits and open questions resulting from exploratively employing *harm* as an analytical concept in violence research.

Context: Torture in Syria since 2011

The rule of violence, including torture and further ill-treatment of political dissidents mainly carried out by the four intelligence services often referred to as the *Mukhabarat* (مخابرات), — the Air Force Intelligence, Military Intelligence, Political Security, and General Intelligence (also referred to as State Security) — as well as the Military Police, has already been a characteristic of the Syrian Arab Republic for some decades (Aljasem, 2023, p. 104; Ismail, 2018; Üngör, 2023; Worrall & Hightower, 2022, p. 6). “All of them operate nationwide prisons and detention centres where torture is routinely applied against detainees” (Üngör, 2023, p. 84), and “while the violence has undoubtedly taken on an unprecedented numerical dimension [since 2011], the structural conditions for the emergence of this violence predate the war” (Shaery-Yazdi & Üngör, 2022, p. 3). In March 2011, following uprisings and demonstrations in Tunisia, Egypt, and Libya, eventually, the so-called Arab Spring arrived in Syria (van Schaack, 2020, p. 21).

The narrative of how the conflict started is as follows: In Daraa (دَرْعَا), which is located in southwest Syria, some schoolboys allegedly sprayed revolutionary slogans like “freedom” and “it’s your turn, doctor” on a school wall — referring to Bashar al-Assad, who is a trained ophthalmologist (Ismail, 2018, p. 159; Yassin-Kassab & Al-Shami, 2016, p. 38). As a consequence, regime forces detained and tortured these children, leading to protests from March 18, 2011 onwards (Cure et al., 2021, p. 3). After the army reacted violently to the mainly peaceful protests by opening fire on the civilians, besieging and raiding the city (Cure et al., 2021, p. 3; van Schaack, 2020, p. 22), people from other areas joined, eventually building up to nationwide demonstrations. Some groups, particularly defectors from the Syrian army, then took on arms and the situation escalated further (Ismail, 2018, p. 159).

By September 2011, the regime’s violent reaction was considered to amount to crimes against humanity by the fact-finding mission of the UN Human Rights Council (van Schaack, 2020, p. 25). Eventually, what started with slogans on a school wall turned into “a popular uprising, then an armed rebellion, and ultimately [into] a civil and proxy war of jihad” (Zisser, 2019, p. 62): While the various rebel forces first seemed to gain momentum, the regime did not surrender but turned to a strategy of total war which included the “cleansing and purging of whole areas of their inhabitants” (Zisser, 2019, p. 63). The use of chemical weapons, the emergence of the so-called Islamic State (IS) — referred to as *Daesh* in this article — and the involvement of various other actors like Russia, Iran, and Israel have, after deduplication by September 2022, led to a varying estimated number of 230,000 (SNHR, 2023a) to 350,000 civilian deaths as “a minimum verifiable number” (Bachelet, 2021), which is based on “people identifiable by full name, with an established date of death, and who died in an identified governorate” (Bachelet, 2021).

About 87 percent of these civilian deaths are considered to have been caused by the Syrian regime, affiliated forces, and militias like the so-called *Shabbiha* (شَبَّيْحَة), which literally translates to “ghosts” (SNHR, 2023a). Half of the Syrian pre-war population lives forcibly displaced either in- or outside the country (Üngör, 2023, p. 84). Estimations state that of the “almost 1.2 million Syrian citizens [who] have been arrested and detained at some point” (SNHR, 2019, p. 3), approximately 15,000 people died under torture inflicted by Syrian regime forces (SNHR, 2023b), while 95,000 people remain forcibly disappeared until today after having been arrested by regime forces between March 2011 and August 2022 (SNHR, 2022). Based on survivors’ accounts, human rights organisations reported many “detention-related violations” (Amnesty International, 2016, p. 14) including:

[P]rolonged periods of solitary confinement; severe overcrowding in cells; lack of adequate access to medical treatment, sanitation, food, and water; being subjected to extreme temperatures; and being held for hours or days in cells containing the bodies of deceased detainees. (Amnesty International, 2016, p. 35)

In addition to these circumstances, “there is hardly any male or female detainee who has not been subjected to some form of torture, which is practiced from the very first moments of detention” (SNHR, 2019, p. 2), a practice that is often referred to as the “welcome party” (Amnesty International, 2017, p. 12). “During interrogation, the Syrian authorities use torture to extract false ‘confessions’ from detainees, which the authorities then use to determine sentences in [symbolic trials]” (Amnesty International, 2017, p. 12). Physical torture methods employed include:

[P]ractices such as burning with flame, chemical acids, gunpowder, insecticides, metal skewers, nylon sacks, as well as electrocution, suspension of the body, being forced to maintain uncomfortable positions for long periods, beating, crushing of body parts or their removal. Beyond physical torture, the regime uses psychological torture including isolation, being forced to hear others being tortured, being forced to imitate animals, and threats to family and friends. (Worrall & Hightower, 2022, p. 9)

These practices are used in combination and during various sessions for the period of detention. Moreover, the torture practices are not confined “to the bodies and minds of those tortured. These individuals or their corpses were used as messengers to the wider community [...] to communicate the state’s power and ability to penetrate individuals’ lives, at scale. Whether, when, or how the regime chooses to release the tortured individual [...] serves as a message to highlight the regime’s authority and control” (Worrall & Hightower, 2022, p. 9). As one survivor shared, concerning the leaked Caesar files depicting people who have died in the Syrian prison system:

The most difficult part of the torture pictures is not the decomposed flesh, the starved bodies, or even the knowledge that the torture is both widespread and systematic, these things have always been elements of our Syrian reality. What is so difficult, that I do not think we have the strength to overcome is the fear that some of these pictures might show us the body of someone we know and we hoped was still alive. (Worrall & Hightower, 2022, p. 10)

Since this article focuses on medical involvement in torture as a specific practice of violence, it does not include a further, general reconstruction of the patterns of torture in the Syrian prison system. Descriptions and testimonies concerning the overall processes of arresting civilians, the *welcome party*, interrogations, and other specific torture practices can be found in Amnesty International’s report “‘It Breaks the Human’: Torture, Disease and Death in Syria’s Prisons” (2016) and the report by the SNHR “Documentation of 72 Torture Methods The Syrian Regime Continues to Practice in Its Detention Centers and Military Hospitals” (SNHR, 2019).

Defining Acts of Medical Involvement in Torture

In contrast to Miles’ (2020) work, this article does not focus on a specific set of actors, namely physicians, but rather aims to include all situations where medical involvement in torture takes place. While there are indeed medically licensed physicians present for practices that require certain authority, such as overseeing executions and mass hangings or the registration of deaths as well as the issuance of death certificates and medical reports, doctors particularly appear in reports detailing cases of medical negligence while other actors provided initial treatment, performed medical procedures, used medical tools, or employed genuine medical methods:

In 601 Military Hospital, the department's manager was an Officer Assistant and there were both military and civilian doctors and nurses. Also, the guards were security forces members and even though doctors performed periodic visits, there is no actual medical supervision. The doctors' tasks are restricted to examining the detainees, diagnosing their cases, and prescribing medicine. In order to increase the detainees' torment, members of security forces, who are medically unqualified, are responsible for installing catheters, injecting patients with their medicine, and changing wound dressings. [...] The cleaning staffers, who are civilians, were requested to clean the department, distribute food for detainees, and transport detainees. They would untangle the detainee from the metal chains and then drop his body in the bathroom or in the hallway, and then security forces would transport the detainees' bodies using ambulances or closed vehicles from the Trauma Department [...]. (SNHR, 2015, p. 6)

Further, it is not always feasible to verify whether those people who appeared to be physicians were indeed licensed doctors according to the definition provided by Miles (2020) or whether they were merely posing as doctors and disguising themselves accordingly. Therefore, in order not to risk excluding these acts (or actors), the term "medical involvement in torture" shall describe all acts of torture:

1. done, assisted, supervised, condoned, or covered up by medical personnel, including licensed physicians, medical students, psychologists, and nurses; or
2. occurring at medical sites such as hospitals; or
3. employing genuine medical methods such as surgeries; or
4. using medical tools such as scalpels, intravenous lines (IVs), or stethoscopes.

Acts of medical negligence and therewith the omission of treatment, despite being present, are included in this definition if they add to the psychological torture and the overall inhumane and degrading treatment as defined in international law. In order not to abandon the main focus — the medical involvement — by discussing whether individual acts amount to torture, this article conceptualises torture in a wide sense, following the Tokyo Declaration that defines torture as "the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason" (World Medical Association Declaration, 1975).

Institutionalisation of Medical Involvement in Syria

Since medical violence in Syria and the developments in the Syrian health sector in general have already been discussed in depth elsewhere (Amnesty International, 2011; Koteiche et al., 2019; Shahhoud, 2020, 2023), it shall suffice for this article to highlight the main developments since 2011 and the process of recruiting medical personnel for detention centres.

Healthcare in Syria has been weaponised and criminalised since the very first days of the uprising in 2011. Hospitals had to report any firearm or further potential protest-related injuries on patients to the authorities, leaving health workers in an ethical dilemma:

[W]hether to obey the government's instructions and report patients to the authorities, knowing that this may very well lead to the patients' arrest, detention, and possible torture, or to ignore or disobey those instructions, put their patients' welfare first and thereby expose themselves to the risk of government reprisals. Many know that the security forces have raided hospitals in which they believed wounded unrest victims were

being treated and are probably aware that a number of health professionals have been detained, and in some cases tortured, for seeking to protect patients in their care. (Amnesty International, 2011, p. 5)

Specifically, the Counterterrorism laws in 2012 and the Emergency law from 1976 “smoothed the co-option of doctors with state violence” (Shahhoud, 2020, p. 65) and put injured civilians in a position “not to seek medical assistance in hospitals for fear of arrest, detention, torture or death” (Caesar Files Group, 2020, para. 64).

Private hospitals and health professionals [...] suspected of treating the wounded without informing the authorities and providing blood units from a source other than the Central Blood Bank have been targeted by government forces. The medical care of patients has also been compromised during security raids of hospitals after which wounded people have been taken away against medical advice. In at least one case, security forces stormed an operating theatre while a patient was undergoing surgery. (Amnesty International, 2011, p. 22)

Next to these raids, and at all stages of the now 12-year-long conflict, the regime specifically targeted healthcare centres and hospitals, leading to a situation where about 70 percent of Syria’s health workforce has fled the country (Bdaiwi et al., 2020).

It is against this background that the overall phenomenon of medical negligence and the recruitment of actors later involved in torture will be discussed in this article. The purpose is not to discuss questions of criminal liability or intent regarding violent acts that will be reconstructed in the following text. Nor is its aim to explain these acts. In lieu of this, the purpose is to highlight various patterns that are part of this practice in Syria to enable comparative discussions about medical involvement in torture across time and space as well as theoretical considerations following from these discussions.

To illustrate this, the following witness testimonies depict the recruitment of medical personnel who worked at the Red Crescent Hospital in Damascus, located within close range to the prison run by Branch 251 of the Syrian General Intelligence Service, which is often referred to as Al-Khatib branch. The information used for this example stems from trial reports by the Syria Justice and Accountability Centre (SJAC) and the International Research and Documentation Centre for War Crimes Trials (ICWC) regarding the trials of Anwar R. and Eyad A. in Koblenz, Germany. These reports can be seen as unofficial summaries of the proceedings.¹

A female witness’ testimony at the German Federal Criminal Police Office indicated:

[T]hat she had studied medicine and worked as a doctor at a hospital which was close to Al-Khatib Branch [and said hospital] was treated [...] as if it belonged to the Branch. The Branch’s employees went there to get treated themselves. Since the beginning of the conflict, detainees from the Branch were transferred to the hospital. The witness said this started at the end of 2011 or even June 2011. [...] Starting in mid-2012, hospital staff also had to go inside Al-Khatib Branch and the witness heard that detainees from this Branch were taken to military hospitals. (SJAC & ICWC, 2021, Trial Report 53, p. 21)

Other witnesses have also provided extensive details:

P51 described how at the beginning of the revolution in 2011, demonstrations were mainly happening on Fridays. He and his colleagues were told to treat detainees at the Branch who were

¹ Information in brackets was provided by the trial-monitors (), square brackets mark omissions or summaries by the author [].

arrested during this first phase. [...] P51 explained that usually someone (from the Branch) came and instructed one or two doctors to go to the Branch. P51 said (the doctors) had no choice but to follow (the order). If they denied, they would have gotten into trouble. (SJAC & ICWC, 2021, Trial Report 46, p. 26)

P36 explained that (Branch personnel) came to the (hospital) administration who then informed the head of the Emergency [...] that a group of doctors and nurses were responsible for treating the detainees. The doctors and nurses took medicine, bandages, and (scalpels). They stayed there for more than two hours and sometimes up to five hours. This was the first time they saw such cases outside of the hospital. (SJAC & ICWC, 2021, Trial Report 38, p. 5)

After a few weeks, special shifts for doctors and caretakers were developed. Everyone at the hospital knew that (employees of [the] Al-Khatib Branch) would call, so they took a bag with medical items and were accompanied to the Branch. [...] They were usually picked up and a man called before that. [...] P51 explained that sometimes there were several doctors who were accompanied by medical personnel. [...] During the first couple months they were usually three or four doctors and three or four caretakers [...] they were all male. (Female nurses) were, however, often [also] told to go. [...] P51 said they did not only go on Fridays, but mainly on Fridays. However, they also went during the week. (SJAC & ICWC, 2021, Trial Report 46, p. 29)

After that, an employee from the Branch came when they needed a doctor and took whoever was at the emergency room. [...] P51 said they had to go downstairs where a heavy gate was opened. They then had to turn right to the cell area where another gate was opened. One or two people were injured, others had a cough, fever, or diarrhea. [...] [T]hey were treated in front of the door. He did not dare to look inside the cells. (SJAC & ICWC, 2021, Trial Report 46, p. 30)

P36 said that there were offices in the basement, but most of the officers' offices were upstairs. (The doctors) were summoned there a few times, such as when there was a special case, the officers wanted to know what happened with a specific detainee in the doctors' care, or the officers wanted to ask about medication prescriptions. (SJAC & ICWC, 2021, Trial Report 38, p. 8)

P51 explained it was always the same ten to fifteen [low-ranking officers] from the Branch who came to the hospital to get the doctors and who also worked in the basement of the Branch. It was well-known that they came from Al-Khatib Branch, since it was opposite of the hospital and only people from the Branch came to the hospital. (SJAC & ICWC, 2021, Trial Report 46, p. 31)

Further, the doctors had to examine whether detainees had died. "However, to issue a death certificate, [they] would have needed ID cards, and [they] would never get that" (SJAC & ICWC, 2021, Trial Report 46, p. 36). The "duty was to tell whether the person was dead" (SJAC & ICWC, 2021, Trial Report 38, p. 8). "The van stopped at the main entrance (of the hospital). There was one or two cars of the same kind and P51 was told to come and see if the people were dead"

(SJAC & ICWC, 2021, Trial Report 46, p. 37). “They only had to say that (detainees) were dead and then (the corpses were) transported somewhere else” (SJAC & ICWC, 2021, Trial Report 46, p. 32).

It can be derived from these statements that the involvement evolved gradually. First being called over to the prison mainly on Fridays; witness P36 eventually treated approximately 200 to 300 patients in more than 1,000 therapy sessions (SJAC & ICWC, 2021, Trial Report 38, p. 9). Additionally, during the months of July to September 2012, about 200 people were brought to the Red Crescent Hospital from the Al-Khatib branch for treatment, of which about 50 percent died (SJAC & ICWC, 2021, Trial report 38, p. 9).

P36 said that he was alright at the Red Crescent. But the doctors saw the injustices facing patients in the basement of Al-Khatib daily. [...] “We cannot do anything. Everyone is afraid. (The other doctors and I) tried to help the patients, but (we did not) contact their families because our situation was difficult and we were under surveillance. We spoke with our colleagues (and decided to) treat patients in the hospital, but we could not help the people in the basement.” [...] The head of the clinical hospital was detained for a week. He tried to resist, but he could not. (SJAC & ICWC, 2021, Trial Report 38, p. 12)

P36 added “that (a doctor’s) duty is like (a soldier’s) duty; it is compulsory” (SJAC & ICWC, 2021, Trial Report 38, p. 13). This already hints at the fact that the health sector has never been independent of the Syrian state.

Throughout the years, intelligence agencies built a surveillance network in civil and private hospitals and medical facilities. These networks consisted of healthcare professionals (mainly nurses), cleaners, guards, and appointed members of the intelligence agency. They monitored and reported any [...] activity of other healthcare professionals and patients [that was considered suspicious]. This facilitated an atmosphere of distrust and fear (Shahhoud, 2020, p. 17).

Moreover, all healthcare professionals in the Syrian Military Medical Service that “were conscripted, contracted (a hybrid), or recruited, [had to] pass a security scan and ‘reputation’ profiling. This included a check on their political activities to determine if they had participated in any ‘activities’ against the state” (Shahhoud, 2020, p. 17). Nevertheless, for many students from underprivileged backgrounds, the Syrian army provided the only opportunity to study medicine, as it operated with lower grade requirements. In the admission process, students had to commit to working for the military after completion of their studies and to being “deployed to all institutions functioning under the Ministry of Defense, including military hospitals, security forces, or military prisons such as Saydnaya” (Shahhoud, 2020, p. 17).

Since Military hospitals had more financial resources and advanced medical techniques, students who were not conscripted (regardless of background) might have also chosen military hospitals for the chance to pursue a certain specialty (Shahhoud, 2020, p. 17). Ultimately, medical students who want to graduate in Syria had (or have) to cooperate with the regime during their residency training and beyond (Shahhoud, 2020, p. 20). This is due to the controls the regime has in education, which is supposedly also reflected in the curriculum:

At the medical faculty in Damascus, medical ethics curricula were insufficient as lectures disregarded any reference to human rights and medical ethics. Syrian Medical professionals interpreted medical ethics as the economic fairness of the healthcare services. An ethical and humane doctor is one who does not exploit the patient economically and treats him/her at a fair cost. (Shahhoud, 2020, p. 14)

Reconstructing Patterns of Medical Involvement in Torture: Cases from Syria since 2011

As briefly mentioned in the introduction, from 2021 to 2023, I extensively studied cases of medical involvement in torture in Syria since 2011. The findings are mainly based on eyewitness memories, either gathered by NGOs such as Amnesty International, Human Rights Watch, the Syria Justice and Accountability Centre, and the Syrian Network for Human Rights, or during the trials against Anwar R. and Eyad A. in Germany concerning crimes against humanity by the Syrian regime.

First, it is important to highlight that this reconstruction is confined to abuse carried out by the Syrian authorities and affiliated militias, even though “non-state armed groups have also carried out abuses against persons in their custody, including torture and other ill-treatment [...]” (Amnesty International, 2016, p. 14). Reports indicate, however, that “the vast majority of detention-related violations since 2011 have been carried out by the Syrian authorities” (Amnesty International, 2016, p. 14), leading to the assessment that these patterns are performed in such a widespread manner that they constitute a practice of collective violence.

Considering that memories fade over time (Combs, 2010) and since the cases were discussed in court about ten years after their occurrence, the statements from the trial reports, in particular, might not be as accurate as they possibly could be. Moreover, it can be assumed that due to the ongoing suppression of any political opposition in Syria and the insecure residence permits of survivors seeking refuge in other countries, the dimension of this phenomenon is severely underreported. This high estimated number of unrecorded cases is further considered to be a consequence of (1.) the low survival rate, (2.) shame, (3.) other psychological effects on survivors (i.e. PTSD rendering survivors unable to report what has happened), and (4.) rare and rather preliminary accountability efforts. Thus, the accounts used for the analysis underlie a significant selection bias towards people feeling secure enough to come forward and report their experiences. Additionally, independent assessments of the conditions in Syrian prisons or (military) hospitals are impossible because there is no access for organisations like the ICRC to these facilities, leading to potentially incomplete pictures of the detention conditions. Further, there might have been some details lost in the translation from Arabic to English in the secondary sources used in this article, so the illustrating testimonies should not be taken as verbatim.

Compounding this, the reconstructed patterns result from a focus on particular sites in Syria entailing specific characteristics. Especially in a well-differentiated *governing* system like the Syrian one, with different (security) forces being responsible for different groups and reportedly serving different purposes, it can be assumed that the torture practices and therewith the forms of medical involvement therein differ from one site to another. The patterns outlined in the following are therefore not considered exhaustive.

Nevertheless, the testimonies that were included in the analysis are considered to authentically portray the medical involvement in torture in the Syrian prison system because the outlined patterns resemble each other in testimonies from several sources and comprise the accounts of various witnesses — regardless of whether they (in)voluntarily participated in the practice or suffered from it.

For the sake of representation, the prevalent patterns of the practice also depicted in figure 2 will now be elaborated upon in an ideal-type order by exemplifying a potential prisoner's journey through the Syrian prison system. Let us call him Abbas Nazir.

What became clear during the analysis is that throughout the prison system, the *presence of health personnel* was guaranteed. Despite differences between the prison facilities examined, witnesses confirmed that medical professionals were present at the sites (Shahhoud, 2020, p. 56). One survivor further explains that a doctor “came every morning at 8 am” (Amnesty International, 2017, p. 36). This means that our potential prisoner Abbas Nazir would encounter health personnel regularly. Yet, an overall condition of *medical negligence and arbitrary treatment* prevailed, as will be further elaborated on in the next section. Another pattern is the preparation of torture through the *anamnesis* of the person tortured or the *exploitation of the patient's medical history*. Explicit examples of this pattern will also be given at a later stage. Thus, Abbas Nazir would not only encounter health personnel, but they might even examine him and advise his torturers on a previous knee injury so that they can exploit that condition during the torture sessions, instead of giving him medicine for it.

Various survivors further recounted the *professionalisation of torture techniques* based on medical knowledge, for example, in order to not leave any physical traces like scars or further evidence of the torture. Abbas Nazir might for example state that:

They took me to a window, which had metal bars on it. It was very high. They stripped me naked and chained my wrists to the bars. My feet were hanging in the air. They covered my hands and wrists with cloth, so that I wouldn't have any scars. They did their best not to leave a trace on my body, since I was a university student — and they would do the same for journalists and doctors, anyone who might talk to the media [bold as emphasis in original]. (Amnesty International, 2016, p. 31)

Another pattern of medical involvement in torture is the *medical oversight of torture* itself to keep the detainees like Abbas Nazir alive for further interrogation or to prevent the guards from contagious diseases. This pattern also includes treating or resuscitating torture victims which prolongs their suffering. Health personnel would for example intervene intense beating if Abbas Nazir showed signs of severe physical distress to prevent a heart attack.

Moreover, *actively torturing* detainees also forms a frequently reported pattern of medical involvement in Syrian prisons. Next to medical personnel being involved in torture, *medical tools* are also reported to have been employed in prison facilities to professionalise the torture methods, for example, for de-nailing. According to a guard, this “reduced the physical effort” (Shahhoud, 2020, p. 55).

The fate of those detained in the Syrian prison system can be distinguished into three (stereotypical) forms, namely (1.) rare cases of release, either as a message to the wider community or accompanied by (medical) acts to conceal the torture, (2.) death due to torture, medical negligence, or medically supervised mass hangings, and (3.) the transport to a (military) hospital.

In the two latter cases, the detainees — either for the registration of their death or for further detainment — are *transported to military hospitals*, which is usually a one-way transport.

The shifting of the meaning of a hospital from a place of healing to one of recurring pain was calculated by the regime to instil a fear of medical professionals and make medical facilities unavailable to anyone fighting against the regime. Doctors and those who work at regime hospitals are not permitted to treat dissident or rebel fighters, at least in these certified medical facilities. The regime used military hospitals initially, and then gradually took over parts of general hospitals to form torture centres, eventually commandeering entire wards of general hospitals for the practice. In the general hospitals, the regime required doctors employed there to treat those who were tortured, implicating those doctors in the violence of the state. (Worrall & Hightower, 2022, p. 13)

If Abbas Nazir was transported to one of these hospitals alive, here, next to the already mentioned and prevailing patterns of medical involvement in torture — the presence of health personnel, medical negligence, and arbitrary treatment, anamnesis and the exploitation of the patients' medical history — he would also experience genuine medical methods of torture.

Survivors and doctors alike testified about *unnecessary medical procedures* such as the amputation of body parts, procedures without sterilisation, procedures performed by students and other personnel not (yet) qualified as training (*training medical procedures on detainees*), treatment and *surgeries without anesthesia*, or the *death induced by genuine medical methods* like injections.

Abbas Nazir's journey throughout the Syrian prison and hospital system, as well as his torments would then probably end in the hospital's basement, where the corpses are *processed* — meaning registered, photographed, and eventually bagged for transport to a mass grave. Therewith, the last pattern frequently reported is the contribution of licensed physicians to the overall system of torture by *falsifying death certificates* as part of the cover-up. Abbas Nazir's relatives might never be informed about his fate, leaving him to become a number in the statistic of enforced disappearances.

Figure 2 summarises the beforementioned patterns of medical involvement in torture reported from Syria since 2011.

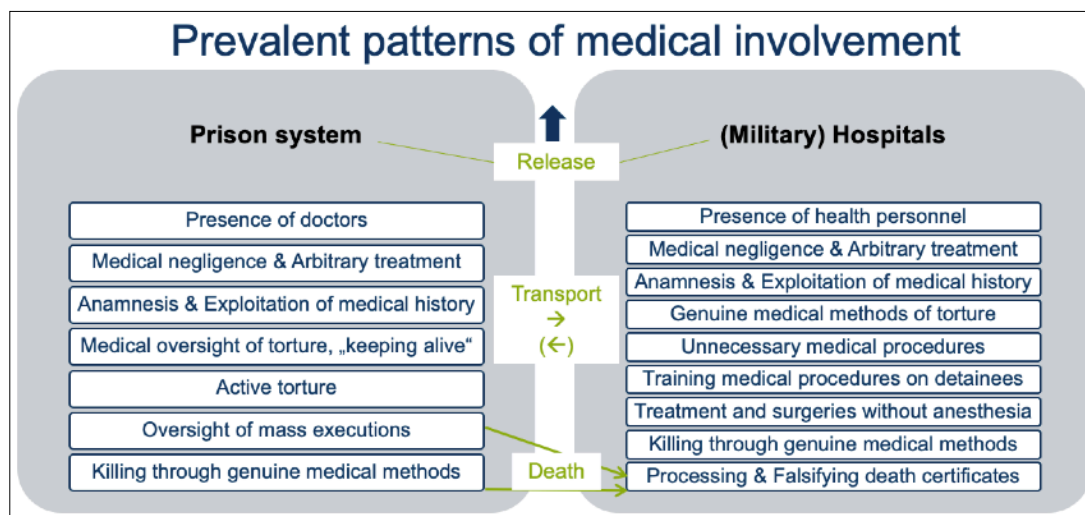


Figure 2. Prevalent patterns of medical involvement in torture in Syria since 2011.

Employing Harm as an Analytical Concept in Violence Research: Three Examples

In the following, I want to provide a glimpse into the experience of three of the reported patterns which seem to be promising to highlight the use of *harm* as an analytical concept in contrast to other concepts employed in violence research: (1.) Medical negligence and arbitrary treatment, (2.) anamnesis and the exploitation of medical history, and (3.) the broader pattern of transporting people to and detaining them in military hospitals.

The following sections, therefore, entail various excerpts from statements made by survivors or witnesses.

Medical Negligence and Arbitrary Treatment

Despite the differences between the various prison facilities in Syria, witnesses confirmed that medical professionals were generally present at all sites. “In Saydnaya prison, there were two military doctors assigned to treat and supervise the medical condition of prisoners. They regularly visited prisoners every day and were accompanied by guards who usually demanded the cell leader [...] [to] report sick prisoners” (Shahhoud, 2020, p. 56). Yet, for any prison facility,

[A]ll of the former prisoners [...] said they had very limited or no access to medical care while detained; this was no different in Saydnaya Military Prison. While there [were] medical staff present in the prison, some survivors reported that they did not receive any treatment; others said that asking for medical attention resulted in additional beating. Some said they were prevented by the guards from attracting the attention of the medical professionals. Most survivors witnessed cellmates dying as [a] result of being unable to obtain medical assistance. (Amnesty International, 2016, p. 57)

This medical negligence can partly be explained by the recruitment process of doctors and nurses as illustrated above and their rules for engagement. These were as follows:

[T]asks were distributed and the doctors were told what to do. They were told to not be scared, not to speak with patients beyond their (medical issues), and not to provide anything beyond medical treatment. If a patient said that he was abused, he was (beaten). (SJAC & ICWC, 2021, Trial report 38, p. 2)

If someone needed antibiotics, they were allowed to give them one pill, but not the whole box. “The orders were clear” [...]

“Give the prisoner what he urgently needs, but nothing more”.
(El-Hitami, 2021)

This is in line with a witness’ observation that in the cells, “sometimes there was a doctor as well, but the other person was the one making decisions. The doctor only fixed open wounds which needed to be [sewn] immediately” (SJAC & ICWC, 2021, Trial report 44, p. 10).

Only being allowed to treat urgent situations on command particularly affects elderly and chronically ill prisoners in need of regular treatment or medicine. The following statements outline some cases and consequences of this deliberate medical negligence:

A doctor came and a pill was put under P41’s tongue to cure his heart issues. The doctor recommended that P41 take the pill every day but the people at Al-Khatib did not follow the recommendation. (SJAC & ICWC, 2021, Trial report 41, p. 16)

P33 described that due to her high blood pressure, she always had to take pills. When she was without her pills for two days, her blood pressure was so high that she suddenly screamed before falling unconscious. Her daughter was so afraid, she knocked against the iron door of the cell, screaming for help. P33 said a guard opened the door and saw P33 lying on the floor. He closed the door to talk to his boss. P33 said they [...] were allowed to go to the room next door, around 30 minutes after the guard first opened the door. A doctor and two nurses were waiting in this room. The doctor gave P33 pills to lower her blood pressure and painkillers. [...] She and her daughter were then taken back to the collective cell [...]. (SJAC & ICWC, 2020, Trial report 14, p. 13)

There was an 18-year-old Syrian Palestinian boy in the cell with us. He had some kind of liver problem; around 15 detainees had it there. They gave them paracetamol, which is what they gave us for everything... One morning he fell over and started bleeding from the rectum. We knocked on the door for the doctor but he didn’t come. They said he would come in 15 minutes. We knocked from 7 am until 11 am. The boy kept bleeding. The doctor didn’t come. We kept knocking. The guard only insulted us. The guards saw the blood but they did nothing. At 11 am, they told us we had to bring him to treatment and clean the blood. We had to force him to stand so we could take him. When he stood up, we realized that his flesh was coming out of his rectum... They took him out of the cell but we saw that after just a few meters he dropped on the floor and he died. (Amnesty International, 2016, p. 40)

Due to the overall unhygienic conditions in the prison facilities, many prisoners suffered from infections and preventable as well as treatable diseases. Survivors reported:

[W]idespread skin conditions, including scabies and lice, and other infectious conditions, in particular [diarrhea]. [...] Several of the interviewed survivors witnessed cellmates dying, usually as a result of a combination of untreated health conditions such as skin diseases [...] As Omar A stated: “From just one small cut on your little finger, you would get an infection. It would swell, and then spread to your entire body”. (Amnesty International, 2016, p. 39)

One survivor described how his cellmate died due to a combination of wounds inflicted by torture and severe medical negligence:

My cellmate had been beaten on his toes, and had [gotten] some wounds from that, and they became infected in his toes and leg. The wounds were becoming black — he developed gangrene. The whole hallway could smell it. The guards stopped coming because of the smell. The doctor couldn't even look at it. He said the legs would have to be amputated... He died on 17 April 2014, in front of me. (Amnesty International, 2016, p. 35)

This testimony is one of the many examples of the experienced arbitrariness of whether helpful treatment is provided to prisoners, whether no treatment is provided, or whether prisoners are punished for requesting medical assistance. Despite the presence of doctors and the explicit medical knowledge of what is needed to be done to save a prisoner's life, no action is taken. This arbitrariness is a frequent pattern and dominates all stages of the interaction process with the health personnel present at the sites. Survivors' statements illustrate that this pattern occurs when (1.) asking guards to see a doctor, (2.) when seeing doctors during their visits in the cell, (3.) when asking for medicine, and (4.) when already being examined by a doctor.

[T]here was a person who used to come routinely more than once a week. He used to open the (cell door) hatch and ask if anyone was sick. If someone said that he was sick, then the person would give him paracetamol or an antibiotic, but sometimes the person gave nothing, and sometimes, the one who answered (that he was sick) would get beaten. (SJAC & ICWC, 2020, Trial report 9, p. 19)

Every day before the doctor came, the guard would warn that if any of the heads of cells said they have an ill person in their cell, that ill person would leave the cell as a corpse. So when the doctor came and asked, of course no one replied. (Amnesty International, 2017, p. 36)

[The judge] asked P51 whether he saw signs of medical treatment (being provided), like bandages. P51 said yes. Wiedner asked how many times. P51 said sometimes people had bandages, but most times they did not. P51 saw no apparent reason for why some people received treatment and others did not. (SJAC & ICWC, 2021, Trial report 46, p. 28)

This arbitrariness of medical negligence can be considered a fundamental part of the practice, especially given the personnel, means, and resources (such as a psychiatrist or dialysis access) that seemed to have been available to the facilities:

After the 36 days, I developed a psychological illness. I started shouting and shivering. I didn't feel like I was in the real world. I lost control. I was so scared of being tortured again. They took me to a psychiatrist in the same place. He told me that he had nothing to do with the army but I didn't trust him. I started shaking. He gave me an injection. He came to visit me in the cell the next morning. He asked me to tell him something, but just I shivered and shook. He turned to the guards and said: "He is going to die anyway. He is useless to us. Let his family take care of him". (Amnesty International, 2016, p. 42)

[Some] prisoners with dialysis in Saydnaya Prison received treatment but died a short period after the treatment session. [...]

Ismael counted the death of about twenty of his Saydnaya inmates who were taking regular dialysis sessions. He explained: When they returned, they were relaxed and healthier, then their health would suddenly deteriorate and then they died within days ... We did not know what happened, but I can tell their catheters were uncovered, maybe they had infections. (Shahhoud, 2020, p. 52)

Similarly, the female detainees in Al-Khatib have also described their interactions in the Branch as characterised by the presence of health personnel, starting with their initial processing at the Branch:

[T]he detainees had to go downstairs and turn right to the place where the Branch's doctor was. There were two female nurses from the Red Crescent as well. They frisked one detainee after the other until it was P32's turn. P32 said all female detainees had to gather at the doctor's office and the female nurses came to take one at a time to frisk them. P32 remembered the frisking felt very humiliating because she had to strip naked, and her sensitive areas were frisked in a way that was close to being a violation (sexual assault). After being frisked, the detainees had to leave this room and go to the left. (SJAC & ICWC, 2021, Trial report 33, p. 4)

Nevertheless, the women did not have regular access to treatment or medicine despite being arbitrarily dispensed certain medications such as painkillers and antihistamines (Amnesty International, 2016, p. 46). Further, "no specialized care was provided for pregnant women or women with existing health conditions. For example, Maisa, a trained nurse, was required to attend to fellow detainees giving birth due to the lack of access to other medical professionals" (Amnesty International, 2016, p. 46).

These conditions seem to (have) be(en) the standard for various prisons, not just the Al-Khatib Branch as discussed in this testimony:

Generally, the doctor did not come and see (the women) or do medical checks. Sometimes they responded to begging and dangerous cases... Women were pregnant there. Some had been brought in to put pressure on their husbands to surrender. I met four pregnant women, two in the Palestine Branch (Military Intelligence Branch 235), one in Kafr Sousseh [كفر سوسة] and one in 'Adra Prison [سجن ادرا]. I helped with the delivery of two babies, because the guards refused to give them medical care... The woman in Kafr Sousseh was from the Philippines. I had to deliver the baby in the cell; there was no help. I had a medical kit with me when I was arrested, I asked the guards to bring this and they did. It took a few hours but both she and the baby were OK. (Amnesty International, 2016, p. 46)

To summarise, even though the "access to medical care, whether for diseases developed as a result of the detention conditions, chronic illnesses, or injuries sustained during interrogation, varie[s] [...]" (Amnesty International, 2016, p. 39) in the different facilities, there is no proper medical treatment despite the presence of health professionals in the Syrian prison system. This can firstly be attributed to the fact that health professionals are bound to the orders of the security forces and their rules of engagement. Secondly, it can be attributed to the arbitrariness of the guards' reactions to detainees asking for treatment, which could result in (limited) treatment with bandages or painkillers, but also in severe beatings and further torture, leading prisoners to refuse from asking for treatment and medicine in the first place.

In view of this, the torture situation can be regarded as the perverse antithesis of the pain clinic, in which professional staff

pulls out all the stops to alleviate the suffering of chronic pain patients as much as possible: the torturers play on the very registers of vulnerability on which the therapy also starts. Their knowledge of this vulnerability, however acquired, allows them maximum effectiveness. Where the patient's social situation is to be changed in a way that gives him as much support and emotional strength as possible, the tortured person is exposed to the greatest possible insecurity and loneliness. Where the therapist works to provide the patient with the most appropriate means of self-management of his pain in order to give him hope, the torturer renders his victim utterly helpless and hopeless. He is not even left with the illusion of control over the pain.² (Grüny, 2003, p. 90)

It can be concluded that this arbitrariness of medical negligence can be considered a deliberate part of the practice, especially vis-à-vis the personnel, means, and resources that seemed to (have) be(en) available to the facilities. This deliberate arbitrariness serves a specific function that is easily imagined: If you get beaten while there is a doctor in front of you, one who could have treated you, then the harm experienced goes beyond the beating itself, compared to when the option of treatment would not even be envisioned.

While the role of health professionals in this section about medical negligence is a rather confined one due to the circumstances outlined above, the following section will describe a gradually more active form of medical involvement in torture

Anamnesis and Exploitation of Medical History

While the degree of institutionalisation of this pattern is not very clear due to limited data, another repetitive part of medical involvement in torture in Syria is the exploitation of a prisoner's medical history (Loveluck & Zakaria, 2017). Some former prisoners recounted initially giving voluntary information about their health problems, hoping to receive better treatment and medication:

They were asking all of us if we were sick or not... I thought to myself I would tell them about (an existing health problem) and they will treat me well. They first asked my friend and he said, "Yes, I have breathing problems — I have asthma." They started beating him until he died, right there in front of me. When my turn came, I told them I was completely alright and I had no problems with my health... After the "welcome" at Saydnaya I was bleeding very heavily from my head and eyebrows, as most of the beatings were directed at the head. (Amnesty International, 2016, p. 51)

They were beating us with a steel bar on the front of the palms. I had had an operation on my hand earlier, and we told them (but) they just concentrated on that spot, and beat it harder. The surgery meant that I had 10 times the pain. (Amnesty International, 2016, p. 52)

They beat me until I was lying on the ground and then they kicked me with their military boots, in the places where I had had my hip operations, until I passed out. (Amnesty International, 2016, p. 31)

For the Al-Khatib Branch, witness reports state that the detainees were regularly visited by a guard accompanied by a doctor and asked cell by cell who required medical treatment. Based on the prisoners' medical information, their vulnerabilities were exploited by beatings:

² Author has self-translated. Cited material has been block-quoted for emphasis.

P46 said [...] the person was accompanied by a doctor. The doctor was standing next to that person. However, the doctor did not talk to P46. He only spoke with people who were injured. P46 said he only spoke to “the guy”. When he asked P46 what he needed, P46 told him he had pain in his stomach and wanted medicine. The guy then hit P46 and told him not to act like a woman. [...] P46 explained that it was always a group of detainees who were taken from the cell. They were asked (by the guards) who had health issues. According to P46, many detainees wanted to go to the hospital because they thought it would be better. The guards already scanned who needed to go and who did not. Four to five detainees were then taken from the cell and had to [queue]. P46 said this procedure happened for every cell, one after the other [...] P46 said “the guy” hit injured people on their injuries on purpose to cause them more pain. (SJAC & ICWC, 2021, Trial report 44, p. 10)

In this case, it can be assumed that the doctor’s presence was intentionally created to make the prisoners reveal their medical problems based on an impression of trust evoked by the presence of someone in the medical profession. Other reports stated that in some facilities, prisoners were examined by health professionals before interrogation and torture sessions:

They blindfolded me and stripped me of clothing. Then they called a doctor. The doctor didn’t talk to me ... he touched my limbs [and] chest, then pressed my stomach ... then he said: “He has strong muscles, start with three.” I didn’t understand what he was doing, I wondered was he abusing me or what? And what did he mean by three? “Three” referred to the level of torture. Qutaiba subsequently experienced seven hours of persistent beating and torture [...]. (Shahhoud, 2023, p. 95)

Since the conditions in the prison facilities vary dramatically in the various types of facilities and their affiliations to the intelligence services, the degree of health personnel’s authority in this practice naturally varies as well. However, it becomes clear that the exploitation of the prisoners’ medical history itself — however the information is acquired — composes an important element in this practice of medical involvement in torture. Further, it can be assumed that the mere presence of someone resembling the medical community or the idea of being sent to a hospital evoked an impression of trust in the detainees leading them to reveal their medical information. This refers to shared knowledge and beliefs about the world, that one would benefit from medical involvement, that health personnel is supposed to heal, and that hospitals are a way out of misery towards healing — beliefs that are eventually severely challenged.

Military Hospitals

As described before, many detainees initially wanted to go to hospitals because they thought that there, they would be treated better. Yet, after being sent to the (military) hospitals, “the hospital security office and administration separated patients into [...] categories and different rooms depending on their referral source” (Shahhoud, 2020, p. 34):

[T]heir personal information was again recorded and they were taken to the sixth floor. P46 told the court that there were multiple rooms on this floor, it seemed to him as if there was a room for every (intelligence) branch, one was for Al-Khatib Branch. There were two soldiers with the detainees in a room. It was the same in every room despite being different Branches. (SJAC & ICWC, 2021, Trial report 44, p. 4)

Some basic and prevailing rules throughout the military hospital system are illustrated in the following statements:

[D]etainees had to hand in their clothes which they did not get back at the end of their stay. At the hospital they only wore hospital gowns. [...] The gowns were white with blue or green dots. (SJAC & ICWC, 2021, Trial report 44, p. 11)

[G]overnment forces put an adhesive tape on detainees' foreheads and wrote a four-digit number and said it was their medical number. They threatened them in case they said their names during their treatment in 601 Hospital [...]. (SNHR, 2015, p. 16)

[T]he detainees were tied to a bed and two of them were tied together by their feet so that two people had to share one bed [...] it was around 1 meter wide with two or three people in it. (SJAC & ICWC, 2021, Trial report 44, p. 4)

As there were reportedly eight to ten beds per room in Harasta hospital, this would amount to some 16 to 30 detainees per room (SJAC & ICWC, 2021, Trial report 44, p. 12). The high degree of authority the security forces — who are reported to be smoking a lot of cigarettes and change in shifts of six hours each (SJAC & ICWC, 2021, Trial report 44, p. 12) — have over the medical personnel becomes particularly explicit by the demands to not treat but mistreat the patients:

Mohammad was a physician who defected from Hospital 601 in 2012 because of increasing peer-pressure for him to torture patients. He said: “One time I was working in the emergency (ER) department as the doctor responsible for ER. Security forces brought a lot of people arrested from the street to the ER. They started to beat them, kicking them, saying bad words. Of course, they were using weapons, but not shooting with weapons but just beating them with weapons. Then they asked us as doctors — sorry to say that, but they said, ‘Don’t treat them, just fuck them!’” (Shahhoud, 2020, p. 59)

The security forces serve as intermediaries between the detainees and the health personnel. These clear rules as to who is in charge and how to behave lead to an overall climate of medical negligence and abuse (Amnesty International, 2011, p. 4; UN Human Rights Council, 2013, p. 7). Resembling the prison facilities, medical negligence also prevails in the hospitals. “Detainees requiring mobility aids such as crutches or a wheelchair to get to the toilet or elsewhere are left without any sort of help, being forced to crawl or use other means to move about” (SNHR, 2019, p. 35) and if completely immobile or incontinent, detainees are left “to lie in their own body waste without [help to] clean them” (SNHR, 2019, p. 35) or provided tools such as bedpans or clean bedding. Further, patients were deliberately left untreated to have their injuries get infected: “‘I’m not going to treat your wound... I am waiting for your foot to rot so that we can cut it off,’ [said] a doctor at Homs military hospital, as reported by a 28-year-old patient who was shot in the foot” (Amnesty International, 2011, p. 4). In 2012, video footage from a military hospital in Homs was leaked confirming that patients were shackled to beds, naked, blindfolded, and bearing injuries from torture (Miller, 2012).³

This leads to the assumption that overall, due to the conditions in the hospitals — prevailing medical negligence, calling detainees by numbers instead of names, being blindfolded and chained to other prisoners on shared beds, irrespective of the type of injury or illnesses — the transfer to a military hospital is an advanced form of torture in itself, where a detainee is tortured “in new ways other than those inflicted on him in the security branches” (SNHR, 2019, p. 33):

³ Videos like these are also investigated in the criminal proceedings against Alaa M., a doctor from Syria who is now standing trial for crimes against humanity in Frankfurt, Germany. He is accused of torturing prisoners who were linked to the opposition against the Assad regime in a military hospital and in a military intelligence prison in Syria, and of inflicting serious physical and mental harm.

In early April, I was among five doctors in the emergency room at the National Hospital in Homs as many cases were coming in with firearm injuries. Among them was a boy, aged around 15, injured in his foot. We, the doctors, were attending to more serious injuries as he waited on a bed... I remember hearing shrieks of pain, so I walked towards the voice and saw a male nurse hitting the boy hard on his injury and swearing at him as he poured surgical spirit on the injured foot in an act that clearly intended to cause the boy additional pain... (Amnesty International, 2011, p. 9)

On the third day I was in the hospital, a colonel-doctor entered our room and hit an injured detainee. He broke his cast on his arm and asked him to name the individuals who he worked with. He continued to beat him until he was unconscious, then he ordered the nurses not give him any medication and to keep him conscious to endure the pain and confess. (SNHR, 2015, p. 17)

We operated on detainees while they were shackled to bed. We didn't address them, we talked to the guards ... we didn't obtain consent ... I became a robot, I felt I had lost my professional identity I fled the country to retain my humanity, sympathy, and medical identity. Am I an accomplice with torture!?! (Shahhoud, 2023, p. 97)

Considerations, Questions, and Conclusions

The last question raised by a doctor who was interviewed by Annsar Shahhoud (2023) brings us to what I would perceive as one of the benefits of employing *harm* as an analytical concept in violence research — the opportunity to overcome oversimplified perpetrator-victim dichotomies. Considerations like these are discussed in the following before raising remaining questions resulting from exploratively employing harm in violence research and presenting implications of this approach.

Considerations

While using a deductive approach and employing a mainstream definition of torture doctoring or violence work very well for some of the patterns reconstructed (those mentioned in the section including all patterns), the three explorations above indicate that they might not have fully captured the experiences of survivors and witnesses of Syrian prisons and hospitals: Deliberately created parts of the practice — such as the mere presence of health personnel in prisons or the transport to a (military) hospital — might have been neglected as they would, in general, not necessarily constitute violent but maybe even helpful acts.

In order to acknowledge the various experiences and manifold manifestations of harm suffered by survivors of medical involvement in torture, I will now elaborate on — for now — four main benefits of employing this concept analytically in violence research (in addition to or instead of previously employed [travelling] concepts like violence or trauma).

Employing harm as an analytical concept in violence research

1. can free us from limiting (legal) categories,
2. allows us to look beyond categories of perpetrators and victims,
3. allows us to also discuss epistemic impacts, and
4. allows us to revisit definitions.

Moving Away from Limiting (Legal) Categories

Legal qualifiers such as the question of intention, the connection to International Armed Conflicts (IACs), or the necessary widespread and systematic manner in which crimes need to be committed to constitute specific categories of crimes (in this case crimes against humanity) are increasingly criticised by representatives of Human Rights Organisations — even though these approaches are

inherent to their own work and accountability efforts. Yet, James Lin, for example, who works for the International Rehabilitation Council for Torture Victims (IRCT), has publicly criticised the “obsession with criminal accountability [and therewith the quantification and qualification of crimes] that creates a gap to the human experience” (Lin, 2023). Thus, in trying to understand the experiences of those that have been or are currently detained in the Syrian prison system, only focusing on actions that constitute crimes might severely misrepresent the people’s experiences. One example of this is what can be called the *painkiller effect*.

“Sometimes the detainees were given antibiotics and Ibuprofen. The guards used to open the hatch and toss the tablets [into the cell]. If fifty people needed medicine, only four or five were given some” (SJAC & ICWC, 2020, Trial Report 7, p. 20), leaving the detainees who were still able to fight over those tablets. Many survivors recounted this treatment as degrading and as a result, said that they felt treated like animals. Moreover, arbitrarily handing out painkillers — in whichever way and no matter the intentions — reinforces the effect of the prevailing medical negligence. Knowing that there are indeed resources available but constantly being reminded of the fact that such resources are being arbitrarily kept from one’s self, might be even worse than simply not being medically treated. It might even be that there were guards or health professionals who genuinely tried to help by tossing painkillers into prison cells. However, in a malicious system like this one, an individual might cause harm despite having the best intentions — an aspect that is not yet sufficiently considered in violence research.

Overcoming Oversimplified Perpetrator-Victim-Categorisations

Employing harm as an analytical concept in violence research further allows us to look beyond categories of perpetrators and victims. The outlined cases from Syria showed us that this is important for at least four reasons.

First, harm can also be caused by artifacts, and not only people. I suggest that harm is qualitatively different if someone in a white coat with a stethoscope around the neck in a hospital beats someone compared to when someone in a military uniform during an interrogation in a prison cell does so.

Artifacts play an essential part in this practice of medical involvement in torture, as they intuitively suggest who seems to be a doctor or nurse, that a room is part of a hospital, that a procedure is a surgical one, or that a fine metal needle is part of a syringe instead of a sewing needle. If the health personnel had not explicitly introduced themselves as such, the detainees have inferred their profession from specific artifacts such as white coats, robes, or stethoscopes:

Prosecutor recalled P32 saying that there was a doctor when she was transferred from Division 40 to Al-Khatib, asking P32 what the doctor was wearing. P32 said he was dressed like a doctor. Polz asked if there was a sign on his clothes indicating that he belonged to the security forces or services. P32 denied. (SJAC & ICWC, 2021, Trial report 33, p. 19)

These artifacts thus allow for a differentiation between medical personnel and guards, even though both “guards and doctors often wore protective clothing or masks. According to ‘Adnan’: ‘The guards would usually wear surgical masks over their mouths, so that they wouldn’t get sick’” (Amnesty International, 2016, p. 35). If these artifacts were missing, if a doctor were for example dressed like a guard, if no medical treatment was provided at all, and if torture would continuously be conducted in prisons instead of medical facilities with beds, hospitals gowns, dialysis machines, and operating rooms, the practice would have a completely different character. Just as the previous sections outlined that the doctors’ presence was strategically created to make the prisoners reveal their medical problems based on an impression of trust evoked by the presence of someone in the medical profession, the same trust in medical institutions — embodied through hospitals, ambulances, and emergency departments — could only be shattered if it was created in the first place. Thus, artifacts representing the medical profession, medical institutions, or medical treatment are invaluable for the practice of medical involvement in torture.

To elucidate, again using the *painkiller effect*: the scarcely provided medicine in prison facilities — often in the form of generic painkillers — upholds the belief of the general possibility to provide treatment, which stands in stark contrast to deliberate medical negligence. The randomly provided painkiller as an artifact thus underlines the strategically prevailing conditions.

It is generally known that during torture:

[T]hings also contribute to the destruction. Everyday objects, which we take for granted when we use them and which usually remain just as implicit as the body itself, lose their familiarity with their equipment character and become objectionable, hurtful objects. After the body and the room, with the furniture, the last attributes of dwelling are now turned against the tortured: The room and its furnishings become a weapon that threatens the victim with annihilation and erases the context of civilization; there is no wall, no window, no door, no bathtub, no fridge, no chair, no bed anymore.⁴ (Grüny, 2003, p. 102)

In this specific practice, however, the use of medical artifacts or those that suggest such an interpretation, instead of artifacts that usually remain implicit, goes even beyond this destructive impact. Being chained to and tortured on a bed in prison by someone wearing a military uniform does not represent the same cruelty as being chained to and tortured with medical tools in a bed in a hospital room by someone wearing a white coat and a stethoscope.

Thus, it can be assumed that in the first place, it is these artifacts and not the medical education or knowledge in itself, that are essential for this practice of medical involvement. As this article, in contrast to the work of Miles, did not focus on the perspective of the “torture doctors” (Miles, 2020, p. 51), but drew on the experiences of those tortured, the hypothesis is put forward that for most patterns of this practice, it is not important whether the person involved is indeed a licensed physician, but rather the detainees’ perception that medical professionals condone what happens to them or even actively participate. It is particularly this perception — based on the use of and reinterpretation of medical artifacts — that the medical profession is an accomplice to their experiences of torture, which characterises this practice.

Since torture does not simply happen anywhere and the nature of their location is determined by their function (Grüny, 2003, p. 92), it can further be assumed that the practice of medical involvement in torture is not only a strategically created, but also a highly institutionalised part of the overall torture system in Syria, as the establishment of this practice requires additional effort, planning, and oversight.

Moreover, artifacts also contribute to maintaining a feigned legitimacy of the torture system, as illustrated above when mentioning the falsification of medical records and death certificates. Here, a piece of paper signed by someone with a medical license — a torture doctor as defined by Miles — eventually yields the power to cover up crimes, human rights abuses, and systematic torture.

To conclude this consideration: Employing harm in violence research enables us to look beyond the actions of those considered perpetrators and victims and take into account that for the people’s experience, objects might play an equally important part.

Secondly, as the quote from one of the doctors involved in this practice stated: Those who violate others can be harmed by what they do and experience too. Therewith, focusing on harm as an analytical concept instead of violence allows for analysing more complex figurations and experiences than the directional concept of violence (c.f. Dhar, 2023).

Thirdly, employing harm as an analytical concept frees us from further limiting categories (next to legal ones), because not only people can be harmed, but also notions like the medical profession in itself. The following example illustrates a survivor who is developing mistrust against anyone who might resemble a health professional:

A medical professional took a look at P8’s wounds and told P8 that he needed an injection. He gave P8 an injection and told him to leave. P8 was afraid because he did not know what was injected into his foot. (SJAC & ICWC, 2020, Trial report 7, p. 29)

Finally, overcoming oversimplified perpetrator-victim-categorisations is relevant because the impact of harm might extend beyond the individuals directly involved in acts of violence. In

⁴ Author has self-translated. Cited material has been block-quoted for emphasis.

the case at hand, for example, the above-mentioned evolving distrust in medical professionals leads other people, other than the ones directly impacted, to refrain from going to the hospital even though they require medical attention. Moreover, this distrust obstructs the documentation of torture and therewith criminal investigations. Thus, upon its implementation, the practice's impact reaches all parts of society, including the following groups of people: (1.) health professionals who had to deal with the dilemma of whether to obey the government's instructions or to expose themselves to the risk of reprisals, (2.) all kinds of people in need of medical treatment, particularly those who avoided hospitals and eventually suffered from their injuries instead of risking torture in one of the medical facilities based on alleged ties to the opposition, and (3.) future generations, since the documentation and accountability efforts are impeded. These societal considerations resulting from employing harm as a broader concept instead of the directional concept of violence could be particularly helpful in transitional justice research, where perpetrator-victim-categorisations are still quite prevalent and there is a tendency to "equate people with this — e.g. with perpetrators — or that — e.g. with bystanders" (Gudehus, 2018, p. 38), rendering indirectly involved people less relevant.

Discussing the Epistemic Impact

The third consideration to take away when employing harm as an analytical concept is that it allows us to also discuss the phenomenon's epistemic impact.

As previously indicated, the mere presence of health professionals at torture sites and the overall medical involvement in torture change what people believed to be true for their whole lives and what used to be shared knowledge: That health professionals are supposed to heal. The artifacts outlined in the previous sections such as hospital beds, medical tools (scalpels, bandages), and even ambulances as a means of transport to a torture site are entirely reinterpreted and represent the dominant ambiguity of this practice of violence: people and artifacts that are supposed to heal, or intuitively represent positive associations, now represent harm, torture, and death.

And this is not exclusively true for those who survived these harmful conditions after directly being exposed to them, or for the survivors' close relatives and friends; it might also extend throughout society to the reader of this article. Since we cannot *unknow* something we have clearly imagined, some of our beliefs about the world would become severely altered. Perhaps, after reading this article and at the next doctor's appointment, when looking at medical utensils, this consideration of why harm should be employed in violence research might even make more sense than those on a theoretical level.

Revisiting Definitions

Finally, employing harm as an analytical concept allows us to revisit and refine definitions such as the previously introduced taxonomy of torture by Steven Miles. In contrast to narrower definitions, employing harm as an analytical concept allows for us to broaden our understanding of *medical involvement in torture* that highlights both the role of artifacts (which evoke a certain level of trust to the surroundings and suggest that someone is part of the medical profession) as well as the omission of treatment (despite having the resources to medically intervene). Further, this omission is even more so relevant if it does not immediately "add to the psychological torture and the overall inhumane and degrading treatment as defined in international law" as previously stated, but also, if it has a harmful *epistemic* impact on the individual or larger societal level.

Therefore, following the above explorations, the term "medical involvement in torture" shall describe all acts of torture:

1. done, assisted, supervised, condoned, or covered up by *who appears to be medical personnel* including licensed physicians, medical students, psychologists, and nurses; or
2. occurring at medical sites such as hospitals; or
3. employing genuine medical methods such as surgeries; or
4. using medical tools such as scalpels, intravenous lines (IVs), or stethoscopes.

Acts of medical negligence and therewith the *omission of treatment despite being present* are included in this definition *if they add to the overall harmful (individual, societal, or epistemic) impact*.

Conclusions and Questions

This article aimed to exploratively employ harm as an analytical concept in violence research, which has proven beneficial particularly in the case at hand — medical involvement in torture in Syrian prisons and (military) hospitals since 2011 — for (at least) four reasons.

Firstly, the analysis is extricated from limiting (legal) categories like intentions and thus, for example, highlighted harm caused by acts that might have been carried out with the best intentions (painkiller effect). Secondly, it allowed us to look beyond oversimplified categories of perpetrators and victims and among others highlight the role of artifacts as well as the possibility of harm experienced by those conducting the torture themselves. Thirdly, it allowed for the discussion of epistemic impacts of the practice that go beyond those immediately tortured and actions that would normally be considered violence. And finally, it allowed us to refine the definition of medical involvement in torture. Therefore, it seems that in this context, the exploration of this concept has proven fruitful.

However, some questions remain after exploratively applying this concept: *What exactly is harm? And how to measure, qualify, or define harm* in this context? While for this article, it was quite practical to inductively employ a very broad concept of harm that goes beyond those of violence (which is often seen as directional and intentional) and trauma (which would be the result of (an) external event(s)), it has not yet been further determined.

Next to the previously outlined benefits, this might also lead to problems, especially since going beyond perpetrator-victim-categorisations and acknowledging that those who were involved in (medical) torture might have been harmed too, could be (mis)interpreted as an attempt to relativise the suffering of those surviving these acts. While there are already tendencies of competitive victimhood (Noor et al., 2008; Young & Sullivan, 2016) concerning narrower-defined concepts like violence, a broader and yet-to-be-defined concept like harm might further invite people to disregard certain forms of harm by relativising these experiences in comparison to other forms of harm or violence. Thus, while using harm as an analytical concept in violence research can be advocated for, especially for inductive, explorative studies, it remains to be seen in which further ways and contexts this concept will be employed and where the boundaries of this concept might lie, if there are any. For now, it can be assumed that using harm as an analytical concept in violence research can specifically investigate phenomena that would lie outside the scope of the concepts of trauma and violence, especially considering that their constant expansion — which Haslam (2016) called *concept creep* — might indicate a need to investigate surrounding phenomena.

After all, the previous pages have shown that while harm is often viewed as a constitutive element of violence, violence is not necessarily an indispensable cause of harm. It might be, that employing harm as a broader category could help differentiate: (1.) phenomena which are — for lack of another suitable category — currently framed as violence; and (2.) phenomena, not yet sufficiently considered in research, which lack concrete violent acts (as we have seen with the epistemic impact of medical involvement), even though they can vastly alter the life of the people (in)directly involved.

Thus, applying the concept to further empirical work might help us get closer to inductively answering these questions. One might, for example, think of similar phenomena of (unintended) harm caused by those supposed to help or cases of inaction in already extensively researched historical incidents such as the genocides in Srebrenica and Rwanda: What was the effect of the peacekeeping forces' presence? Could their presence have had similar adverse or perpetuating effects on the population they were supposed to protect as they eventually failed or were prevented to do so? By answering these questions, the idea of harm caused by doing good or at least by meaning well as one example of a phenomenon outside the scope of but in close relation to current definitions and incidents of violence could be explored further to help fathom the extent of harm as an analytical concept in- or outside of violence research.

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