Since February, 2020, there has been a string of hearings in the context of Mr Assange's US extradition trial. A timeline is provided in the appendix. His treatment throughout has been described as "shocking and excessive" by the International Bar Association's Human Rights Institute (IBAHRI).[3] He has been held in a bulletproof enclosure unable to fully hear proceedings and denied meetings with his lawyers. He was strip-searched, handcuffed 11 times, moved to five different holding cells, and had privileged client–lawyer communications seized.[3]

Mr Assange attended, by videolink due to ill health, only one hearing, missing the four following hearings because of COVID-19-related restrictions and medical risks.

Prison lockdowns in the UK have prevented meetings with his lawyers to prepare for future hearings. These irregularities and excesses cause helplessness, arbitrariness, threat, and isolation, all key components of psychological torture.

Mr Assange is at grave risk from contracting COVID-19. As he is non-violent, being held on remand, and arbitrarily detained according to the UN Working Group on Arbitrary Detention,[4] he meets internationally recommended criteria for prisoner release during COVID-19.[5,6] A bail application with a plan for monitored home detention was refused, however, and Mr Assange is held in solitary confinement for 23 h each day.

Isolation and under-stimulation are key psychological torture tactics, capable of inducing severe despair, disorientation, destabilisation, and disintegration of crucial mental functions. Given recent attacks against journalists, the psychological torture of a publisher and journalist sets a precedent of international concern.

Human rights organisations and others have called for Mr Assange's release and condemned the extradition proceedings. Amnesty International has advocated for Mr Assange's release on bail.[5] The Council of Europe considers[7] Mr Assange's treatment to be among "the most severe threats to media freedom".[8]

We reiterate our demand to end the torture and medical neglect of Julian Assange.[1] IBAHRI states that, in view of Mr Assange being a victim of psychological torture, his extradition to the USA would be illegal under international human rights law.[3] The World Psychiatric Association emphasises that withholding appropriate medical treatment can itself amount to torture,[9] and under the Convention Against Torture, those acting in official capacities can be held complicit and accountable not only for perpetration of torture, but for their silent acquiescence and consent.

As physicians, we have a professional and ethical duty to speak out against, report, and stop torture.[10,11] Silence on Mr Assange's torture might well facilitate his death.[12] The silence must be broken. Now. Please join us!

We are members of Doctors for Assange. This Correspondence has 216 signatories, representing 33 countries. A longer version of this Correspondence and the list of signatories is available in the appendix.

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See **Online** for appendix

For the **Convention Against Torture** see https://www.ohchr.org/en/professionalinterest/pages/cat.aspx

Time for WHO to declare climate breakdown a PHEIC?


Bay Ismoyo/Contributor/Getty Images

At the opening plenary of the World Health Assembly in May, 2019, Richard Horton urged member states and the Secretariat of WHO to recognise climate change as a planetary emergency. A few days later, during a side event on air pollution, climate change, oceans, and health sponsored by the Government of Sweden, the Minister of Health for the Seychelles Jean Paul Adam argued that climate change has to be recognised as a public health emergency at the international level. Johan Giesecke[1] once stressed that as public health emergencies of international concern (PHEICs) evolve into more complex forms, it becomes necessary to identify gaps in

the alarm and response mechanism of the International Health Regulations (IHRs). WHO could and should use the authority it derives from both its constitution and the IHR to declare climate breakdown a PHEIC.

WHO's Constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[2] Climate breakdown threatens each element of that definition. The Constitution also authorises WHO "to foster the ability to live harmoniously in a changing total environment"[2] and allows the Board "to take emergency measures within the functions and financial resources of the organisation to deal with events requiring immediate action".[2] We are now experiencing "a catastrophic collapse of nature's ecosystems".[3] Climate breakdown requires immediate action.

IHRs define a PHEIC as "an extraordinary event which is determined... (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response".[4] Climate breakdown is just such an occurrence, increasing the conditions suitable for disease transmission. For example, global vectorial capacity of the dengue virus is increasing in step with global carbon dioxide emissions.[5] These effects are global, thus requiring a coordinated international response.

By declaring a PHEIC, WHO would protect and respect its mandate, global public health, the planet, and the wellbeing of present and future generations; mobilise political will and funding needed for climate action; and convey a sense of urgency. If ever there was a PHEIC, it is climate breakdown. WHO should declare it as such.

We declare no competing interests.

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US Global Gag Rule increases unsafe abortion

The Trump administration issued the Protecting Life in Global Health Assistance policy in 2017. This policy is an expansion of the Global Gag Rule that blocks US global health assistance to foreign non-governmental organisations that provide, counsel on, refer to, or advocate for abortion services; even if they do so with their own funding and in countries where abortion is legal. Following an additional policy expansion in 2019, foreign organisations that comply with the policy must now attach it to all subgrants that they give to other foreign organisations, including those that do not involve US global health assistance.

Researchers have found three crucial effects of the policy: decreased stakeholder coordination and reduced discussion related to sexual and reproductive health and rights; reduced access to contraception with accompanying increases in unintended pregnancy and induced abortion; and negative outcomes beyond reproductive health, including weakening of health-care system functioning. These consequences are all associated with adverse maternal health outcomes.[1]

For example, after choosing not to comply with the Protecting Life in Global Health Assistance policy, a non-governmental organisation in Madagascar was forced to close clinics, end outreach to rural areas, and terminate a programme that provided free contraceptives to 17 000 women and girls living in poverty. Madagascar also had stock-outs in family planning commodities. Unsurprisingly, local health practitioners in Madagascar now report that many women are seeking care to treat the complications of unsafe abortions.[2,3] This increase is in line with the finding that the policy increases a country's typical abortion rate by 40%, while reducing the use of modern contraceptives by 13·5%, which was reported by Brooks and colleagues in 2019.[4]

Unsafe abortion is directly linked to risk of death in childbirth: approximately 8% of maternal deaths worldwide are attributable to complications from unsafe abortion. An important consideration is that poor women and women living in low-income countries are more likely to have unsafe abortions than affluent women. Three quarters of abortions done in Africa and Latin America between 2010 and 2014 were unsafe, compared with approximately half of all abortions globally. The proportion of abortions taking place in low-income countries has also increased from 78% in 1995, to 86% in 2008.[5]

These figures are particularly concerning given that, according to WHO, almost all morbidity and mortality associated with abortion could be prevented through education, the use of effective contraception, the provision of safe and legal induced abortion, and timely care after abortion.[6] Furthermore, these statistics most likely represent a gross under-representation of the problem as the scarcity of empirical data, even in settings where abortion is legal, reduces the accuracy of abortion estimates. Data are scarce for adolescents, sex workers, people who use drugs, sexual