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HEALTH AND HUMAN RIGHTS

SPECIAL FOCUS ON DOCTORS AND TORTURE

Doctors and Torture

TORTURE is condemned universally as inhuman and as a calculatedly cruel practice. As such it should not find any place in any civilised society. Yet its widespread use is a truth that cannot be denied. To a greater or lesser extent it is resorted to in all countries. Why is this so? Why do countries which apparently place a high value on human rights routinely practise and condone physical and mental abuse of its opponents both in times of war and in peace?

Torture has been recorded in history since the ancient times and there have been references to torture in the 12th and 13th centuries, and even earlier. The Tudor and Stuart monarchs made frequent use of torture. But it was during the religious and political struggles of the 16th and 17th centuries in European countries that there was more open discussion of the subject. Indian history also is replete with references of torture of political prisoners.

It was in the 18th century that a movement against this cruel inhuman practice was initiated with the hope that by the end of the 19th century this practice would be abolished altogether. But the reality of concentration camps in Germany under Nazi rule, with their largescale use of torture wiped off this optimistic belief. However, it was in the aftermath of the war and the end of Nazi rule that serious attempts were first made to set out norms of conduct for medical people participating in torture.

Torture is among the most reprehensible aspects of state repression. Unlike other forms of repression, it can be carried out in private and in such a manner that none but those against whom it is used come to know of it. So it can be practised with impunity within smiling democracies professing to be 'open' societies ensuring freedom of speech, expression etc. to its citizens.

Torture is used to suppress dissent against the state and its ideology in various ways. It is used extensively to extract information—and this use is often protrayed as being justified in order to maintain 'law and order'. But more importantly, it is used to strike terror in the hearts of those who oppose it. A torture victim becomes a warning to others who may follow his/her path for much the same reason that feudal barabaric societies displayed severed heads or conducted public hangings.

The Indian state has consistently and widely used torture to quell rebellion and protest whether it is to supress movements of minorities for autonomy or those which pose an ideological challenge to the state. In Telengana in the 40s and Naxalbari in the 60s and 70s and Bihar, Punjab and Andhra Pradesh in the 80s the state's police have systematically and routinely used torture on political prisoners so much so that they have perfected methods which cause pain and suffering to the individual but leave no mark which can be displayed to monitoring authorities, such as they are. And in all this at some level or other—whether in diagnosing and treating a victim of torture or in issuing death certificates of those who have succumbed to it or in many other numerous small ways—is involved a health worker most often a medical professional, who ironically enough is pledged to preserve life and reduce suffering.

Here there are two aspects which must be touched upon. Usually torture in most codes is defined to mean the abuse of person in the custody of the authority. In a larger sense and increasingly, it includes the physical and mental abuse meted out to the friends, relatives and others close to the victim. Again the evidence of torture becomes valid only with the involvement of the medical profession. Secondly, sexual abuse and assault on women held in custody or held for 'questioning' is becoming increasingly frequent. And in most cases, it is medical evidence which will help in bringing the victimisers to book. The medical profession thus plays a crucial role in protecting human rights.

The United Nations, in 1975, in its Declaration, has defined torture as: "Torture means any act by which severe pain or suffering, whether physical or mental, is intentially inflicted by or at the instigation of a public official on a person for such purposes as obtaining from or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent in or incedental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners. Torture constitues an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment." (see *Health and Human Rights*, ICHP/cinpros 1986, p 25). As Paul Sieghart states (p 95) the "prohibition against torture contains no limitations or exceptions of any kind and *allows no derogation in any circumstances—not even in times of war or public emergency treating the life of the Nation*" (Emphasis added).

Doctors As Victimisers and As Victims

It is an irony that the "protectors of law and order"—the police themselves employ the method of torture which is so universally condemned but what is unthinkable is the involvement of doctors (actively or passively) in torture, particularly when they happen to be police, prison or military doctors. The conflict between the ethical positions of the prison doctors and national laws are real and superficially bewildering but certainly not unresolvable

As Dr. Wyner of the World Medical Association clarifies "that if a certain legislation is criminal and contrary to ethics, the doctor has the deontological duty to ignore it and in some cases, even oppose it when practicing his profession". It is thus gratifying to learn and in Switzerland, the prison doctors and subordinate medical authorities alone are responsible for the prisoners' health and thus find it easy to maintain the patient-doctor relationship. Such a trend must spread to other countries as well.

So far as the ethical codes on the subject are concerned, there need be no ambiguity in the mind of the medical practioner. The UN Declarations and codes relating to Principles of Medical Ethics, the Declaration on the Protection of All Persons from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and (iii) Standard Minimum Rules for the treatment of Prisoners and related recommendations are amply clear and concise to permit any grey areas. Furthermore, the statements by various orofessional associations viz. that of (i) physicians, (ii) psychiatrists, (iii) nurses and (iv) psychologists, also leave no stone unturned in respect of the ethical positions. [Elsewhere in the issue we carry the full text of some of there codes and statements]

Even so, there are reports revealing medical practioners attending the interrogation of punishment centres for examing the detainees to certify on their health and later administering treatment for the victims' injuries. Some of them are even reported to be active in torture. How else could one explain some of the more modern and sophisticated methods of torture which could not have been devised without the active participation of experts (forensic) having a high degree of knowledge in the area? To the extent that many of its members contribute to torture, the whole medical fraternity must also share his guilt and it is for the respective medical councils to pull up its members. Medical fraternity must do all that is in its collective power towards eliminating this obscene, cruel, inhuman practice that is internationally outlawed.

The doctor compounding or assisting torture discarding the ethical norms is obviously only one facet of the situation existing today, but consider the scene where (and this is known to take place more after in some countries under some dictatorial regimes) the doctor has had to pay heavy penalties including his life for having listened to his consciense and abiding with ethical codes laid down. Often a doctor is penalised for helping the victim of state repression or for supporting movements for justice. One such victim of police brutality was Dr. Ramanadhan who was shot dead the state police in September 3, 1985. We publish in this issue a short biographical sketch of the doctor-activist. Undoubtedly, health workers who use their professional skills to help those who protest against the state are themselves vulnerable. Particularly under the dictitorial regimes the reality is such that people's protest against such actions cannot be expected to operate. International pressures need to be applied and the Human Rights wing of United Nations have a pertinent role in this.

What about the repurcussions of torture on physical and mental health of the tortured? On the family? And the responsibilities of medical and social scientists in this matter? It is clearly imminent that torture would both physically and more importantly mentally wreck the victims' and ruin them and their families but sadly there are not enough studies on this important issue in our country [see the case of Archana Guha in this issue]. Such studies, if nothing else, could serve well towards eliminating the apathy towards this distantly occuring nonetheless sensitive issue. Surely it must be remembered that until empathy towards the tortured does not percolate through vast multitude of peoples, elimination of this inhuman practice will keep eluding us time again.

Why have we chosen to highlight the issue of the role of the health worker in preserving human rights, especially in state torture? Firstly, because as we have seen, the medical profession plays a crucial role both in perpetrating torture but also in publicising its use and bringing the victimisers to book. In doing so, the health workers themselves become vulnerable to attack. It is therefore necessary that a strict code of conduct be implemented. Also, doctors who are placed in vulnerable situations must be ensured safety. In times of war, for instance, medical help is always ensured safe conduct. In times of peace too, it should be possible to safeguard the life of people who give medical aid.

Secondly, there nas been an increasing incidence of police torture and inhumanity. With the growth of political awareness, mass movements are on the upswing. The state is bound to become more repressive and if this repression is to be effective while maintaining the facade of democratic functioning, it has to use such instruments which focus on the individual and are hidden from the public eye. There is a tendency to legitimise torture (say, by branding the victims as 'terrorists'). Again there is need to create an awareness of where, how and in what circumstances torture takes place and the role the health worker plays in this. It is also necessary to empower them with information on how they can be coerced into abetting torture and what they can do about it.

While we highlight some of the major issues in the field and how the international community of health workers have tackled it this is certainly not the last word on the subject. There is a particular lacuna about information on India. We hope the issue will generate discussion on the issue and lead to documentation of the Indian situation.

Anil Pilgaokar

Medicine at Risk

Doctor as Human Rights Abuser and Victim

Amnesty International

For over a decade now, the Amnesty International has been working to eradicate the use of torture. In this effort, it has paid special attention to the role of health workers in human rights violations as well as the violation of the human rights of people working in health.

[This paper was prepared by the International Secretariat of the Amnesty International and circulated as a background paper for the International Seminar on the same subject at Paris from January 19 to 21, 1989.]

IN 1978, Amnesty International convened an international meeting in Athens which brought together some 100 health professionals from 13 countries to discuss 'medical detection and effects of torture, the need for treatment, rehabilitation and compensation of torture victims, and other work of the medical profession against violations of human right'. Among the many conclusions and recommendations made by the participants, three themes were identified for continuing study and campaigning. Two of these particularly relevant to the subject of 'medicine at risk' were strategies for the prevention of torture, and the elaboration of medical ethics codes against torture [1].

Despite continued widespread human rights violations, there have been since 1978 a number of positive developments with regard to prevention of medical involvement in torture and two in particular might be mentioned here. The first was the adoption by the United Nations General Assembly on 18 December 1982 of the Principles of Medical Ethics Relevant to Health Professionals, Particularly Physicians, in the Protection of Prisoners from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. These, together with the World Medical Association's Declaration of Tokyo of 1975, offer the clearest ethical guidance to the health professional confronted with the problem of torture.

The second encouraging development has been the active public opposition of some medical and other associations to torture and their commitment to disciplining those health professionals who participate in it. However in the face of continuing human rights violations and despite committed work by human rights groups and professional bodies [2], a wider degree of engagement by health professionals in supporting colleagues at risk would make a significant contribution to the fight for human rights.

This paper reviews some of the issues implicit in the theme 'medicine at risk': that is, participation of health workers in human rights violations, the violation of the human rights of those working in health care; and the role of professional associations in dealing with these abuses.

Human Rights Standards

Human rights violations are contrary to the principles of all the healing disciplines. Ethical standards of a wide relationship of the practitioner and his or her client should be based, *inter alia*, on principles of beneficience and respect for the client's autonomy.

However, dealing with prisoners poses certain difficulties to medical and other personnel since prisoners have lost their freedom with concomitant restrictions on their autonomy; secondly, the health professional has obligations with regard to the detaining authority which they may see as threatening the concept of medical confidentality, in practice if not in principle. Nevertheless, the ethical standards have been clearly set out.

The World Medical Association, at its assembly in Tokyo in 1975 adopted a declaration which stated that it was prohibited for a doctor to "countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim to such procedures is suspected, accused or guilty. . ." [3] The World Psychiatric Association, in its Declaration of Hawaii [1977] stated, *inter alia*, that "no procedure shall be performed nor treatment given against or independent of a patient's own will. . ." and "the psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group. . .".

Nurses' and psychologists' associations have also set out the responsibilities of these particular professions with regard to the care of those in detention.

An international code applying to all health professionals— The Principles of Medical Ethics—which embodied many of the elements of the Declaration of Tokyo, was adopted by the United Nations on December 18, 1982. This states categorically *inter alia* that it is a contravention of medical ethics for "health personnel, particularly physicians, to engage... sub acts [of] torture or other cruel inhuman or degrading treatment or punishment".

Unfortunately, in spite of the elaboration of these comprehensive standards, there is irrefutable evidence that in many countries professional expertise continues to contribute to human rights violations.

These breaches of professional ethics are manifested in a number of ways, including participation in the practice of torture. Direct involvement takes a number of forms:

Examination of prisoners before interrogation to ensure that the prisoner can survive torture or to find sen-

sitive foci for exploitation during torture.

To monitor the torture process: to stop the torture if it threatens the prisoner's survival or to resuscitate the victim where necessary.

To 'patch up' the victim after torture, possibility to undergo further sessions or to make the prisoner presentable for appearance in court or after release.

To provide the police or other authorities—under pressure or by free will—with false certificates stating that the prisoner is in good health or, in event of their death, certifying a false and misleading cause of death.

To advise the torturers or to directly use medical or psychological techniques during interrogation eg. giving sensitive information obtained during the interview or helping administer drugs [4].

Other abuses of medical expertise constituting infringements of medical ethics and human rights include:

Falsely certifying that an individual is seriously mentally ill in order to have them committed forcibly to a mental hospital so as to curtail their political activities.

Advising executioners of the progress of an execution to enable them to continue or to modify whatever technique they are using.

Using medical skills to mutilate an individual as a punishment or advising others in the application of such skills. [5]

Reasons for participation by health professionals in behaviour of the kind cited above can, for the most part, be the subject of speculation only; most of those who take part in torture do not set out their reasons for doing so [6]. However there is enough evidence to suggest that the motives [or rationalisations] include some of the following:

Fear of consequences of refusal or seeing open opposition to abuses as an impossibility for whatever reason. Doctors under military discipline may feel, like others, that they are under irresistable pressure to participate. In his study of the behaviour of Uruguayan physicians during the period of military rule [1973-1985], Bloche could identify only *one* health professional working with political prisoners who openly refused to collaborate in abuses [7].

Identification with the cause of the torturers and a belief that serious measures are justified by what are seen as serious threats to national security. The Chilean Physician Alfredo Jadresic cited a young doctor explaining his collaboration in military abuses at the Chile stadium after the 1973 coup in these terms: "What do you expect? We are at war."[8]

Defining the doctor's function as essentially a bureaucratic one. A female Uruguayan prisoner testified to pleading with a doctor to obey his physician's oath; she said that he replied: "I'm just doing my job" [9].

Inadequate understanding of professional ethics: for example, to see it as the health professional's job to minimise suffering resulting from torture or ill treatment through participation in the interrogation process.

The psychological mechanisms and ideological analysis by which doctors have justified participation in systematic human rights violations have been examined in depth by Lifton [10] with respect to doctors in Nazi Germany, and more briefly with respect to Uruguay during the military government of 1973 to 1985, by Bloche [11].

Lifton suggested the concept of "doubling"—ie. the creation of a second self who could participate in a lifestyle and professional conduct which might ordinarily be seen as in conflict with the individual's underlying moral and professional values. He refers to the 'technicalisation'of the medical role [dissociating the technical aspects of their function from the moral values associated with it] and a related psychological distancing. [Lifton points, for example, to doctors'participation in selection of victims for the gas chambers, noting that "by not quite seeing it, they could distance themselves from the very killing they were supervising; selections could be accepted as an established activity and seem less onerous than specially brutal tasks [such as medical collusion in torture to produce confessions]..."; pp. 199-200]. He suggests [p. 200] that such a view could also be interpreted that selection for killing was so onerous "that Nazi doctors called forth every possible mechanism to *avoid taking in psychologically what they were doing* [emphasis in original]. Other authors have dealt more generally which the motivation of tortures [12].

Participation in Violations of Human Rights

Evidence of the participation of health professionals in abuses of human rights is, unfortunately, readily found but perhaps not widely discussed or acknowledged. The report by the British Medical Association on doctors and torture, published in 1986, concluded that "the evidence given to the [BMA] leaves no room for doubt that doctors are involved in many parts of the world in the physical and psychological torture of prisoners."[13].

Documents published by AI both before and since the publication of the BMA report as well as reports from other medical associations [Chile, Uruguay, Turkey] and organisations [such at the American Association for the Advancement of Science] all confirm this phenomenon.

Abuses of psychiatry for political reasons have been documented in the USSR, Czechoslovakia, Romania and Yugoslavia, though the role of psychiatrists in these abuses probably varies from those who knowingly falsify a psychiatric diagnosis with the express purpose of colluding in the imprisonment of a political or social nonconformist to those whose role is more passive and who fail to protest at the failure of the legal system and their

own colleagues and superiors to protect individuals from such abuses. The motivations of psychiatrists involved in these practices probably include genuine belief in the diagnoses such as 'sluggish schizophrenia' [14] as well as conformist, bureaucratic and ideological reasons [15].

With regard to the death penalty, the role of the health professional is not well documented apart from the case of the USA where there has been a vigorous debate on the ethics of professional participation. Physicians have argued against [16] and for [17] physician involvement in execution by lethal injection, though the American Medical Association has made clear that any involvement would be unethical.

The American Psychiatric Association and the American Nurses Association have both ruled participation unethical though some psychiatrists still present evidence based on hypothetical questions relating to the defendant's "future dangerousness" in death penalty cases [where their evidence can be highly influential in securing the death penalty] despite the view of the APA that such testimony has no value as expert testimony since psychiatrists are no more accurate in such predictions than non-psychiatrists [18]. The ethics of such behaviour has yet to be ruled upon by the APA.

The involvement of health professionals in certain other human rights violations—flogging, amputations, prolonged solitary confinement—is more contentious since these abuses are provided for by a law in some countries and doctors' presence at their infliction may be specified in law. However, some individual doctors and some medical associations have nevertheless protested at such punishments being carried out in their country. For example, the Mauritanian Association of Doctors, Pharmacists and Dentists expressed 'deep concern' at the involvement of physicians in the punitive amputation carried out on three convicted thieves in September 1980. Another amputation took place in June 1981 and again a doctor was involved though it was reported that two amputations carried out in 1982 were executed by a medical auxiliary following refusal by doctors to assist. In Pakistan, both the Karachi branch of the Pakistan Medical Association and the Pakistan Junior Doctors, Association voiced their concern about flogging of political prisoners.

"The problem with torture", concludes the BMA report, "is not whether it is right or wrong. It is how to detect the subtle changes in relationships which lead to the doctor's acquiescence in torture." It continues:

> The experience of those who gave information to the [BMA] demonstrates that a refusal to compromise is effective in the early stages, firstly because the doctor himself is less likely to be compromised and secondly because the apparatus of the state is likely to be vulnerable to concerted public opposition. Once these early stages have been allowed to pass unchallenged, it may be too late to avoid serious abuse. [19]

Violation Against Health Professionals

Reasons for repressive measures being taken against health professionals include: (i) their real or perceived peaceful or violent political activities against the government; (ii) their activities in human rights groups; (iii) their professional activities or criticisms of government health policy; (iv) their giving treatment to injured armed opposition; (v) the perceived deterrence value of making an example of the health professional; (vi) accidental reasons [for example, being in the wrong place at the wrong time].

In many, perhaps most cases, persecution cannot be simply attributed to one unique reason. Doctors who are active in political opposition groups may also be engaged in human rights activities. Similarly, those who criticise health standards or government policy on health may also be seen as politically active, or involved in human rights action and so on. While the rights of doctors to participate in political activity must be protected in the same way that any citizen's political rights should be protected, the particular focus of this paper is the risk of doctors being victimised because of their professional or human rights activities.

The actions which precipitate repressive measures can, in some cases, be substantially attributed to human rights activities: the attacks are focussed and concern individuals whose prominence owes a lot to their position as a human rights activist.

In Colombia for example, two doctors active in the Committee for the Defence of Human Rights [CCDHM] were the victims of political killings in 1988. On 25 August 1988, Dr Hector Abad, aged 65, and Dr Leonardo Betancur, aged 41, were shot as they were leaving a service for the president of a teachers' union who had been killed that morning. Dr Abad, who was a former Dean of the Medical School, reported receiving death threats shortly before his murder.

In the USSR, those involved in the work of the unofficial Moscow Working Commission to Investigate the Use of Psychiatry for Political Purpose were detained in connection with their work in documenting the practice of internment of prisoners of conscience on spurious psychiatric grounds. Dr Leonard Ternovsky [b. 1933], a radiologist, was arrested on April 10, 1980 in Moscow and was charged under Article 190-1 of the RSFSR Criminal Code with "anti-Soviet slander". He was subsequently convicted and sentenced to three years' imprisonment. Other members of the Working Commission were also imprisoned in the period 1980 to 1981, culminating in the sentence of 12 years' imprisonment and internal exile for Dr Anatoly Koryagin, the psychiatric consultant to the Working Commission, following the publication in the British journal *The Lancet* [20] of a paper describing his experiences of the misuse of psychiatry for political purpose.

More widespread and indiscriminate repression occurred in Syria during the period 1978 to 1980, when there was pressure on the Syrian government from lawyers and other professionals to implement measures included lifting the State of Emergency in force since 1963. In early March 1980, meetings of dentists, pharmacists, engineers, lawyers, teachers and medical association representatives in different Syrian cities urged the introduction of reforms. On March 21 1980, a general conference of the Syrian Medical Association met in Damascus and passed a resolution which included the following demands:

> Re-affirmation of the principle of the citizens' rights to freedom of expression, thought and belief;
> Denunciation of any kind of violence, terror, sabotage and armed demonstration, whatever the reasons and justifications;
> Abolition of exceptional courts;
> Release or trial of all detainees

On March 31 1980 a one-day strike was called by lawyers in Damascus and this was supported by other branches of the Bar Association and by other professional associations including members of the Syrian Medical Association. Shortly after the strike, the national congress and regional assemblies of the Medical, Engineers and Bar Associations were dissolved by the Syrian Ministerial Cabinet. In the days that followed the dissolution, numerous lawyers, doctors and engineers were arrested and held without charge or trial. At least two doctors were later executed and some 100 doctors remain imprisoned still without charge or trial more than eight years after their arrest.

In Central America, a wide range of health professionals were subjected to intense repression in El Salvador and Guatemala in the period 1980-1982 and in a less intense way in subsequent years. Some of the victims of the torturers and 'death squads' were active government opponents but the institutionalised nature of the abuses and the impunity with which those perpetrating the human rights violations could act meant that those with little or no political engagement were also victimised.

In July 1980 a United States Public Health Association Commission visited El Salvador and reported an alarming pattern of military incursions into hospitals and abduction and murder directed against health personnel. Their report listed 23 health professionals who were killed or had disappeared in the period January to June 1980. Many were tortured before their murder.

In Guatemala, an equally disturbing pattern of attack directed against health workers was occurring. On April 23 1981, a 32-year-old doctor, Dr Otto Raul Letona, was shot 12 times in the torso by unidentified gunmen as he stood in the emergency ward of a hospital in Antigua, talking to a patient. Another 13 medical personnel were reported killed during the first half of 1981 alone.

In both El Salvador and Guatemala, being involved in providing health care to the rural poor appeared to be linked—in the view of the military—with subversion and opposition. The widespread and indiscriminate nature of the repression particularly in the early 1980s suggests that the definition of subversion was very loose and could be applied to anyone working to improve the situation of the peasants. In some cases, doctors *did* treat members of armed opposition groups or individuals who had sustained bullet wounds; occasionally doctors were detained for giving this help though it was much more common that a doctor suspected of 'aiding the opposition' would be dealt with extra-judicially.

Where torture, 'disappearance' and political killings are everyday realities [as in El Salvador and Guatemala during the period under consideration], the options for a health professional appear rather limited. Even if they wish to remain outside politics they are obliged to ensure that anyone with injuries should receive medical care and must, as a consequence, evaluate the best way to ensure the physical security of their patient. A number of cases have been documented where medical personnel have not reported patients with bullet wounds as required by law in circumstances where they could reasonably fear that reporting would lead to their patient being tortured or killed. This action in itself may make the doctor a target for human rights violations.

Since 1980, Amnesty International has issued medical appeals on behalf of health professionals in the following 30 countries: Afghanistan, Algeria, Argentina, Benin, Chile, Colombia, Cuba, Czechoslovakia, El Salvador, German Democratic Republic, Guatamala, Iran, Laos, Nepal, Paraguay, Republic of Korea, Romania, Singapore, Somalia, South Africa, Sri Lanka, Sudan, Taiwan, Turkey, Uganda, USSR, Uruguay, Vietnam, Yugoslavia, Zaire.

Role of Professional and other Associations

The central role of professional associations in assisting health personnel at risk of being pressured into collaborating in, or remaining silent about, human rights violations is alluded to in the last article of the WMA's Declaration of Tokyo. this states that:

> The [WMA] will support, and should encourage the international community, the national medical associations and fellow doctors, to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the uses of torture or other forms of cruel, inhuman or degrading treatment.

Unfortunately, in many cases the associations themselves are under severe threat or acute repression. As noted above the Syrian Medical Association was dissolved after calling for human rights reforms in 1980; members of the Turkish Medical Association were prosecuted in 1986 for calling for an end to the death penalty in Turkey; the Chilean Medical Association was raided by security agents in 1986 at the time it was organising a meeting with international participation on the

theme of the role of medical associations in the protection of human rights.

However, it is striking that medical associations and other professional bodies in countries where abuses occur systematically have frequently *not* spoken out against them nor taken any apparent action against health professionals collaborating in torture, covering up deaths following ill-treatment or carrying out other unethical acts. Individuals doctors seeking support from their association or an obvious body to whom to complain, may interpret the silence of the professional association [sometimes correctly] as a disinterest in the issue or an unwillingness to speak out. If the professional leadership will not speak out, the pressure on individuals to remain silent is all that greater [21].

Recently, the Uruguayan Medical Association has been active in promoting the idea of an international medical forum for the hearing of evidence of medical abuses against human rights. This idea was recently supported at a meeting in Geneva in October 1988 of the International Council of Health Professionals. Some specialist groups of professionals have looked at ways of using their own expertise to counter human rights violations. For example, forensic scientists have contributed to the drafting of a protocol for the investment of deaths in detention or in order circumstances where a proper investigation of the cause of death should be instituted [22], and have participated in a number of investigations which have had the objective of clarifying the fate of persons whose deaths have been the subject of deliberate cover-ups.

While professional associations have a major role to play in disciplining their members who assist human rights violations and protecting members who are active in promoting human rights or who resist pressure to collaborate in torture, other bodies also have an important role. Human rights bodies can help translate and circulate information, endeavour to break down isolation and give support to both opponents and victims of torture and other bodies; they can press governments to fulfil their international treaty obligations; and they can offer international solidarity—something which has been remarked on as being of great support to those facing repressive governments.

Notes

[1] The third was the rehabilitation of torture victims. See *Violations of Human Rights: Torture and the Medical Profession*. Report of an Amnesty International Medical Semianr, Athens Mach 10-11 1987. AI Index: CAT 02/03/78.

[2] One of the associations which reversed a previous quiescent stand on human rights was the Colegio Medico de Chile which, after being permitted by the government to elect its own officers for the first time since 1972, embarked on a programme of medical ethical awareness. including the novel initiative of publishing, in November 1983, the WMA's Declaration of Tokyo as a paid advertisement in a major Santiago daily newspaper. This reflected the Colegio's belief in the importance of a public and professional understanding of ethical standards particularly with regard to torture. See, Stover E. *The Open Secret: Torture and the Medical Profession in Chile*. Wahsington: AAAS, 1987.

[3] For this and the codes cited below see Amnesty International. *Ethical Codes and Declarations Relevant to the Health Professions*. AI Index ACT 75/01/85, 1985.

[4] Information on these abuses can be found in a number of Amnesty International reports [see, for example, *Recent Torture Testimonies Implicating Doctors in Abuse of Medical Ethics in Chile*. AI Index AMR 22/29/84, May 31 1984] and also British Medical Association. *The Torture Report*, London: BMA, 1986; Stover E Nightingale. *The Breaking of Bodies and Minds*. New York: Freeman, 1985.

[5] In Sudan in 1983, a surgeon was included in a delegation sent to Saudi Arabia to learn amputation techniques; he later participated in the carrying out of the first amputations in Sudan. In Iran, a new amputation device was apparently designed in 1985 with the advice of medical personnel in Teheran.

[6] Occasionally some talk to the press; see a series of press articles about a Brazilian doctor who, in 1988, was disciplined by the Regional Medical Council of Rio de Janerio for assisting torture in the 1970s: *Istoe*, April 1, 8 and 15 1987.

[7] Bloche MG. *Uruguay's Military Physicians: Cogs in a System of State Terror*. Washington: AAAS, 1987.

[8] Jadresic A. 'Doctors and Torture: An Experience as a Prisoner'. *Journal of Medical Ethics*, 1980, 6:124-7.

[9] ['Yo solo cumplo con mi trabajo'.] *Testimonies on detention procedures, torture and prison conditions in Uruguay*. AI Index: AMR 52/18/79, June 25, 1979.

[10] Lifton RJ. *The Nazi Doctors*. London: Papermac, 1987.

[11] Bloche, *op cit*.

[12] Ruthven M. *Torture: the Grand Conspiracy*. London: Weidenfeld and Nicolson, 1978; Peters E. *Torture*. Oxford: Blackwell, 1985.

[13] BMA, *op cit*. p. 22.

[14] Reich W. 'The World of Soviet Psychiatry'. In Stover and Nighingale [eds], *op cit*.

[15] See Bloch S, Reddaway P. *Russia's Political Hospitals* London: Gollancz, 1977.

[16] Curran WJ, Casscells W. 'The Ethics of Medical Participation in Capital Punishment by Intravenous Drug Injection'. *New England Journal of Medicine*, 1980, *302*:226-30.

[17] Kevorkian J. Medicine, 'Ethics and Execution by Lethal Injection'. *Medicine and Law*, 1985, *4*:307-13.

[18] Cited in AI. *The death penalty in the [USA]: an issue for health professionals*. AI Index: AMR 51/40/86, 1986.

[19] BMA report, *op cit*, p. 22.

[20] Koryagin A. 'Unwilling patients'. The *Lancet*, 1981, *i*:821-4.

[21] Individual doctors can nevertheless speak out. The case of Dr Wendy Orr in South Africa is illuminating. On commencing work as a district surgeon in the Port Elizabeth area in 1985, she was struck by the number of prisoners alleging assault most of whom had injuries consistent with their allegations; she noted the complaints on the medical record cards, adding that these should be investigated. When her efforts to have some action taken on the persisting compalints of police brutality and torture had no effect she sought an urgent ruling from the Supreme Court restraining police from assaulting prisoners. An interim injuction was made. See Rayner M. *Turning a Blind Eye?* Washington: AAAS, 1987.

[22] *The Minnesota protocol: Preventing arbitrary killing through an adequate death investigation and autopsy*. A report of the Minnesota International Lawyers Human Rights Committee. Minneapolis, 1987.

Steve Biko and South African Medical Community

mary rayner

Steve Biko a leading exponent of Black Consciousness was detained and tortured to death in September 1977 by the South African police. The doctors who were called in to examine the detained, although aware of the fact that he had been tortured failed to raise a protest. Nor did they ensure that the detainee was adequately cared for when at last he was moved to a hospital. Their role raised a controversy in the professional bodies in South Africa which has subsequently had an impact on the attitude and the functioning of these bodies and of individual doctors on the medical profession's ethics regarding the torture of prisoners.

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EARLY on the morning of September 7, 1977, Dr. Ivor Lang, a Port Elizabeth district surgeon[1] was summoned by Col. Goosen, head of the security police in the Eastern Cape, to examine a detainee, Steve Biko. A leading exponent of Black Consciousness—the mixture of ideas and action which emerged in the early 1970s to unite black people against apartheid and white supremacy—Steve Biko had been held in detention under Section 6 of the Terrorism Act since August 19.[2] On the morning of September 6, the detainee had been taken from Walmer police station cells to security police headquarters for interrogation. At 7.30 a.m. on September 7, Major Snyman, leader of the day interrogation team, had reported to Col. Goosen that Biko was acting strangely and was refusing to react to questions. Col. Goosen asked Dr. Lang to examine the detainee for a suspected storke. In Goosen's presence Lang examined the detainee, who was lying on a mat, manacled to a metal grille in an office at security police headquarters.

During his examination, which was made at floor level, Dr. Lang found a laceration on the patient's upper lip which was edematous, a superficial bruise over the sternum at approximately the level of the second rib, a ring mark around each wrist, and edema of both hands, feet and ankles. The detainee also walked with an ataxic gait and spoke in a slurred manner. When asked by Col. Goosen for a medical certificate, Dr. Lang wrote:

> This is to certify that I have examined Steve Biko as a result of a request from Col. Goosen of the security police who complained that the above-mentioned would not speak. I have found no evidence of any abnormality or pathology on the patient.[3]

The next day Dr. Lang was summoned again. This time he examined the detainee in the company of his superior. Dr. Benjamin Tucker, the chief district surgeon for Port Elizabeth. The patient, still shackled to the grille, was lying on a mat now soaked with urine. During the examination, Dr. Tucker observed a possible extensor plantar reflecx in the patient,[4] who also complained of a pain in his head. Tucker and Lang contacted Dr. Hersch, a specialist in private practice, who agreed to examine Biko at Sydenham Prison Hospital. On September 9 Dr. Hersch performed a lumbar puncture, the results of which revealed bloodstaining in the cerebrospinal fluid. A neurosurgeon, Dr. Keeley, was consulted by phone. Although Keeley seemed not unduly worried regarding the patient's condition, he advised Dr. Lang to keep Biko under close observation.[5]

Apparently because the prison hospital had no observation facilities, Dr. Lang arranged for the patient to be transferred to the Walmar police station cells. As his final entry in the bed letter (medical record) at Sydenham Prison Hospital on September 10, Dr. Lang wrote: "No change in condition. Have informed him [Biko] that Dr. Hersch and myself find no pathology, that lumbar puncture was normal, and as a result I was returning him to the police cells."[6]

At the police station, the patient was left lying on a mat on the cement floor of the cell. Occasionally a police warden looked in on him. On the afternoor of September 11, Col. Goosen again called Dr. Tucker to the station. A police warden had found Biko collapsed, glassy-eyed, hyperventilating and frothing at the mouth. After a five-minute examination Dr. Tucker suggested that the patient be transferred to a provincial hospital in Port Elizabeth, but Col. Goosen refused to allow it. Tucker acquiesced in this and gave his permission to the police for the patient to be transferred by motor vehicle 750 miles to Pretoria.[7]

On the night of September 11 the semi-comatose patient, naked and handcuffed, was placed on some cell mats on the floor of a Land Rover and driven to Pretoria Central Prison. Biko was unaccompanied by any medical personnel during this long journey. No medical records on Biko's condition were sent with him. Several hours after his arrival at the prison Biko was examined by district surgeon Dr. A. Van Zyl. Without any information about the patient other than that he was refusing to eat, Dr. Van Zyl administered an intravenous drip and a vitamin injection. During the night of September 12, 1977, Steve Biko died lying on a floor mat and unattended.[8]

The Inquest

Three months later, spectator and reporters crowded daily into the large and ornate Old Synagogue building in Pretoria to hear the police and the doctors give evidence during the inquest into the death of Steve Biko. The proceedings attracted wide attention in South Africa and abroad, partly because of Steve Biko's political stature and also because of the notoriety gained by the police during the past year's student uprisings.

During the two weeks of evidence and intense cross-examination, the police witnesses were unable to explain the physical and mental deterioration Steve Biko underwent between the morning of September 6 when he entered the interrogation room and the morning of September 7 when he was first seen by a doctor. Their difficulty in providing a convincing explanation was dramatised when the counsel for Biko's family revealed in court a copy of a telex sent by Col. Goosen to police headquarters, in which he referred to an injury "which was inflicted on Mr. Biko at 0700 hours on September 7 after which he refused to speak".[9] The inquest magistrate, nonetheless, concluded that the likely cause of death was:

> Head injury with associated extensive brain injury, followed by contusion of the blood circulation, disseminated intravascular coagulation as well as renal failure with uraemia. The head injury was probably sustained during the morning of Wednesday, September 7, 1977, when the deceased was involved in a scuffle with member of the Security Branch of the South African Police at Port Elizabeth. Date of Death: September 12, 1977. The available evidence does not prove that the death was brought about by any act or omission involving or amounting to an offense on the part of any person.[10]

If the magistrate failed to use his power under the Inquest Act to draw conclusions concerning the culpability of the police, he did make an implicit judgment on the conduct of the medical practitioners who had attended to Steve Biko during the last week of his life. At the close of the inquest, the magistrate sent a portion of the inquest record containing the evidence of Drs. Lang, Tucker, and Hersch to the South African Medical and Dental Council. In so doing, the magistrate was acting in terms of Section 45 of the Medical, Dental, and Supplementary Health Service Professions Act of 1974, which provides that:

> Whenever in the course of any proceedings before any court of law it appears to the court that there is *prima facie* proof of improper or disgraceful conduct on the part of a registered person, or of conduct which, when regard is had to such person's profession, is improper or disgraceful, the court shall direct that a copy of the record of such proceedings, or such portion thereof as is material to the issue shall be transmitted to the South African Medical and Dental Council.[11]

During the inquest, the magistrate had received the advice and assistance of professors I. Gordon and J. A. Olivier, both pathologists of high reputation. Professor Gordon later stated that "at no time was there any doubt whatsoever in the mind of the presiding Judicial Officer or the two Medical Assessors, of whom I was one, that in terms of the Medical, Dental, and Health Professions Act...there was a *prima facie* case [of professional misconduct] against Dr. Lang and Dr. Tucker..."[12]

The results of the post mortem examination conducted by the Chief State Pathologist, Dr. J. O. Loubser, and the general autopsy performed by a neuropathologist, Professor N. S. F. Proctor, in the presence of two other leading pathologists including Dr. Jonathan Gluckman, were unequivocal in establishing that the cause of death was head injuries.[13] The inquest magistrate found that the injury which led to the patient's death was probably inflicted just prior to Dr. Lang's first visit at 9.30 a.m. on September 7, 1977. Photographs of the patient taken after his death clearly and unmistanably revealed a large scab on the patient's forehead.

All of this notwithstanding, Dr. Lang failed, apparently, to seen the injury on the forehead on the occasion of his first and subsequent examinations, according to a group of private South African doctors who submitted complaints to the South African Medical and Dental Council. Dr. Lang, they claimed, failed to attach any significance to the lip injury, or to other bruises and visible symptoms which Dr. Lang admitted in court having noticed. He failed to ask the patient for his account of how these injuries were sustained. He did not prescribe any treatment, carry out any routine blood or urine analysis tests, or take the patient's temperature at any stage. He did not recommend to the police that Biko should not be left lying on the floor or urine-soaked bedding. He failed to keep the patient under medical observation following Biko's transfer from Sydenham Prison Hospital to the Walmer police station. He did not keep Hersch and Keeley fully informed about the patient's condition or of actions taken which may have affected his condition. He failed to insist upon proper hospitalisation, or to oppose Dr. Tucker's acquiescence in the plan to send the patient to Pretoria. And only Steve Biko died did Dr Lang make any notes or reports of his findings.[14]

When counsel Sydney Kentridge pressed Dr. Lang during the inquest to explain his behaviour towards the patient, Lang stated that he believed the detainee was deliberately feigning illness. Col. Goosen had informed Lang that Biko had studied medicine for four years and that Biko had exhibited 'similar symptoms' during his previous period of detention. Lang claimed that Col. Goosen's comments had influenced his opinion. When questioned about his failure to ask Biko for his account of the lip injury and chest bruises, Lang stated that he had assumed they were sustained while the poilice were attempting to restrain the detainee, who, according to Col. Goosen, had gone into a rage on the morning of

September 7 and had attempted to assault an officer with a chair.[15]

On the issue of proper hospitalisation, Dr. Lang told the court that neither he nor Dr. Tucker had any option but to acquiesce in security police demands. Dr. Lang stated that he had the 'impression' that Mr. Biko could not be transferred to a non-prison hospital because he was regarded as "a security risk." Dr. Lang buttressed his defence by claiming that "we [district surgeons] are restricted in the sense that we cannot tell them where we wanted a detainee... You cannot buck the security branch."[16].

The effect of this particular line of defense was vitiated when Dr. Lang later admitted to the court that he had not really pressed the issue of hospitalisation with Col. Goosen. Goosen, Dr. Lang said, could have interpreted his reference to hospitalisation as necessary for diagnostic rather than treatment purposes. When asked if he at any stage suggested to Goosen that Biko was a sick man in need of treatment in a hospital, Dr. Lang acknowledged: "No, I did not."[17]

The two most egregious instances of questionable behaviour raised against Dr. Lang during the inquest concerned his medical certificate and his final entry in the bed letter. Col Goosen told the court that his request for a medical certificate on September 7 was 'plain logic'. Dr. Lang's certificate was, he added, completely satisfactory for his purposes. In the certificate. Dr. Lang had recorded as the reason for holding the medical examination that Biko "would not speak". Yet, in his later report to the pathologist conducting the post mortem, Dr. Lang wrote: "The detainee had refused water and food and displayed a weakness of all four limbs and it was feared that he had suffered a stroke." But, when asked to explain the discrepancy between these two statements, Dr. Lang could only reply: "I cannot explain it. It is inexplicable."[18]

In the second part of Dr. Lang's certificate of September 7, he noted that he had found no evidence of any abnormality or pathology. Dr. Lang admitted that this claim was "highly inaccurate" as he had found evidence of bruising, a lip injury, and edematous swelling of the hands, feet and ankles. Counsel Sydney Kentridge then asked Dr. Lang if it hadn't occurred to him that, "if, at some later stage, Biko might appear in court and complain about the way he was treated while in security police custody, [his] medical certificate would be a most important piece of evidence"? The doctor agreed that it would be but added that the possibility had not occurred to him on the morning of September 7.[19]

Dr. Lang had similar difficulty in explaining the contents of the entry in the Sydenham Prison Hospital bed letter, dated 10 September. He admitted that the statement regarding the lack of evidence of pathology was false. he knew that the cerebrospinal fluid was blood-stained, and

Excert From the Inquest

Kentridge: Why didn't you stand up for the interests of your (Counsel for patient? Biko family)

Lang: I didn't know that in this particular situation one could override the decisions made by a responsible police officer.

Gordon: Why didn't you say that unless Biko goes to hospital you would wipe your hands of it?

Lang: I did not think at that stage that Biko's condition would become so serious. There was still the question of a possible shamming.

Kentridge: Did you think the plantar reflex could be feigned?

Lang: No.

Kentridge: Did you think a man could feign red blood cels in his cerebral spinal fluid?

Lang: No

Kentridge: In terms of the Hippocratic Oath are not the interests of your patients paramount?

Lang: Yes.

Kentridge: But in this instance they wer subordinated to the interests of security?

Lang: Yes.

(Inquest into the death of Steve Biko, Proceedings, in Bernstein, *Biko*, p. 94).

that Dr. Hersch had reconfirmed the extensor plantar response. Nevertheless, Dr. Lang argued that the misstatement arose from the inadvertent omission of the word "gross" infron of "pathology".[20]

In his testimony, Dr. Tucker, the chief district surgeon in Port Elizabeth, attempted to explain his behaviour towards the patient, both claiming that he had accepted Col. Goosen's theory of feigned illness and by alluding to constraints affecting district surgeons' activities in relation to political detainees. At one point Professor Gorden pressed Dr. Tucker to explain why he did not tell Col. Goosen that he would disclaim all responsibility as a doctor if Biko was not taken to a proper hospital. Dr. Tucker replied that he did not consider the patient's condition as serious, as "there was still this question of a possible shamming on his [Biko's] part." He did concede, however, that no one could feign an extensor plantar reflex or red blood cells in the cerebrospinal fluid. he also accepted that, in terms of the Hippocratic Oath, the interests of his patients should always be paramount. But in this instance, Tucker admitted, as had Dr. Lang, that they were subordinated to the interests of security. "I didn't know," he said, "that in this particular situation one

could override the decisions made by a responsible police officer."[21]

On several occasions during the inquest porceedings, Dr. Tucker contradicted himself. Although stating at one point his belief that Biko may have been feigning illness. Tucker claimed elsewhere in his evidence that the though of head injury had occurred to him. yet he failed to ask the detainee the source of his lip injury or the police if Biko had received a blow on the head. Dr. Tucker initially denied that his reticence came from dealing with the security plice. When Kentridge pressed him on this issue, however, Tucker reponded. "I would say no, you don't [ask questions in that situation]." After a five minute court adjournment, Dr. Tucker, in resuming his evidence, retracted his statement. "Questions asked by the district surgeon," he said, "are not banned in the security offices." He further claimed that, "at all times I have always had all the co-operation necessary from the security police. When we require information and when we require things to be done, then they are done."[22]

If Dr. Tucker's assertion about the co-operativeness of the police was correct, then it threw on onus of responsibility for the fatal pretoria journey directly on to his shoulders. Tucker's evidence shows that he deferred without protest to Col. Goosen's refusal to allow the detainee local hospitalisation. Dr. Tucker consented to Goosen's alternative proposal tht the patient be transported to Pretoria by motor vehicle. The only aspect the arrangements he claimed to have insisted upon was the need for a soft mattress. Tucker stated later, however, theat he neither saw it as his responsibility to check the vehicle used nor reassure himself that there was infact a mattress, blankets, and a pillow for the patient. Furthermore, he did not consider it part of his responsibility to insist that Biko be accompanied by a medical attendent or his medical records.[23]

On the crucial matter of the state of Steve Biko's health the day before his death, Dr. Tucker had written that he found no positive sign of organic disease and that the patent's condition was satisfactory. Under questioning Tucker admitted that he had found the patient lying on the floor with forth at his mouth and hyperventilating. He had found the patient weak in the left arm and apathetic. He admitted that he knew of the extensor plantar reflex. Nevertheless, when challenged to admit that "in this situation no honest doctor could have advised that Biko's condition was satisfactory," Dr. Tucker persisted. "In the circumstances, [I] though it was," he said.[24]

In his final submission made to the court on behalf of the Biko family, Counsel Sydney Kentridge strongly criticised the indifference displayed by Drs. Lang and Tucker towards the patient. Their relationship to Col. Goosen, he charged, "was one of subservience bordering on collusion." And their behaviour carried a significance beyond the present case. For "the medical profession's general reputation has led couts in the past, whenever an issue arose as to whether a prisoner seen by a doctor had been assaulted or not, to place great if not absolute reliance on the district surgeon's findings." Kentridge submitted that in this case "the proved facts show that not only can the court not rely on the evidence of Drs. Ivor Lang and Benjamin Tucker, but that an analysis of the evidence show that they joined with the security police in a conspiracy of silence." The very best that could be said, he argued, was that "they turned a blind eye." Kentridge concluded that the doctors' neglect of the patient's interests in deference to the requirements of the security police "was a breach of their professional duty, which may have contributed to the final result."[25]

Excert From the Inquest

Kentridge : Why did you not ask the obvious question, whether the man received a bump on the head?
Tucker : I did not ask it and that is all I can say.
Prins (magistrate) : Did you ask Biko?
Tucker :. No.
Kentridge : Was it not possible you were reluctant to embarrass Goosen?
Tucker : No.
Kentridge : Either from reading about it or from your own experience have you no knowledge that the police assault people in custody?
Tucker : I have. (Further answer inaudible).
Kentridge : But on that occasion you did not ask?
Tucker : No, I did not. Where persons are brought to me for examination my report is completed on a special form. This is all I am required to do. This history was given to Dr. Lang... The restraint [on the morning of 7 September] could have resulted in the damage.
Kentridge : You accept it as a fact, what Goosen told you?
Tucker : May I put it this way? If am called to see a patient and he has a cut onhis head, then I am interested in treating him and not in how he got the cut.

(Inquest into the death of Steve Biko, Proceedings, in Bernstein, *Biko*, p. 85)

Response of South African Medical Dental Councils

The South African Medical and Dentral Council (hereafter referred to as the Medical and Dental Council) is South Africa's principal regulatory body controlling the medical and dental professions. The thirty-four member

The Witwatersrand medical faculty noted in its resolution that the Medical and Dental Council, as the purported watch-dog of the ethics of the profession, had been zealous; even over-zealous, in the severity of the punishments meted out in the past for even minor infringements of medical ethics. Yet, in the present case, they found it difficult to accept "that the council [had] applied its collective mind to the problem of the Biko doctors in a purely objective and dispassionate way."[38]

Despite these protests and the indications that medical associations in other countries were beginning to review their ties with South African medical organisations, the Medical and Dentral Council announced in October 1980 that its dismissal of the complaints against the Biko doctors was final and irreversible.[39]

The Medical and Dental Council's controversial decision forced critics to turn to the Medical Association of South Africa (MASA), a non-statutory professional organisation whose membership is purely voluntary.[40] On June 18, 1980 Dr. Jonathan Gluckman, a pathologist who had attended the post mortem on Biko on behalf of the deceased's family and a member of MASA's Federal Council, presented the association's secretary general, Dr. C. Viljoen, with a letter signed by 38 association members. The signatories called for an inquiry to determine whether Dr. Benjamin Tucker "...is a fit and proper person to continue to be a member of this Association." (Dr. Lang was not a member of MASA.)[41]

In accordance with MASA's Articles of Association, Dr. Wiljeon referred the letter with copies of a portion of the inquest record to the Cape Midlands Branch of the association where Dr. Tucker held membership. Unlike the Medical and Dentral Council, MASA lacked wide powers of inquiry and punishment. Its powers of censure over its members were limited to that of expulsion, with the initiative for this lying at the branch level and not at the national level. In this instance, the Cape Midlands Branch notified the MASA's Federal Council two weeks later "that a charge of unethical conduct against Dr. Tucker could not be sustained" and advised that "the case now be closed."

The executive committee of MASA's Federal Council met in August 1980 and accepted this recommendation. The committee also resolved that the findings of the Medical and Dental Council and its inquiry committee "be noted." Even so, the Federal Council's executive committee did raise questions concerning the conformity of the medical care received by Biko with the WMA guidelines in the Declaration of Tokyo. The executive committee acknowledged that the lack of conformity probably contributed to the "subsequent unfortunate course of events." Nevertheless, the executive committee shifted the focus of its questioning away from the conduct of the doctors to the possibly restrictive effects of existing laws and regulations upon doctors operating within the prisons.[42]

Two additional resolutions adopted by the Federal Council's executive committee alluded to the growing domestic and international controversy surrounding the response of the medical establishment to the charges against the Biko doctors. The committee defended the 'integrity and bona fides' of the members of the Medical and Dental Council and its inquiry committee, and MASA's Cape Midlands Branch. They also expressed MASA's satisfaction that the decisions of these bodies "had in no way been subject to outside influence and that there had not been any attempt at a 'cover-up' with regard to the conduct of the practitioners concerned."

In contrast, the Federal Council's executive committee viewed the critics of these bodies as proceeding on the basis of flawed newspaper reports, "which were frequently incomplete, biased, or based on political rather than ethical or humane considerations." The executive committee concluded that if evidence of improper or disgraceful conduct could not be found by the Medical and Dental Council's inquiry committee, the members of the MASA executive committee "could not be expected to submit to pressure or to violate their own consciences by laying a charge simply to satisfy the demands being made."[43]

To members of the South African medical community anxious to investigate fully the conduct of the Biko doctors, it appeared that the medical establishment had closed ranks. This impression was strengthened by statements published in September 1980 in the *South African Medical Journal*, the official journal of MASA.[44] The journal contained a statement by the Federal Council's executive committee recapitulating the discussion and resolutions passed at its August meeting. The chairman of the Federal Council, Dr. J. N. de Klerk, pointed out in the journal that three separate medical bodes independently had reached the same conclusion, namely, "that in light of the evidence available to them, and taking into consideration the particular circumstances surrounding this whole matter, the doctors were not guilty of negligence or of improper or disgraceful conduct." For those colleagues who still disagreed with these findings, de Klerk had only cold comfort. "Manifestly," he concluded, "the [Medical and Dental] Council itself is not able to reopen the matter, while the ethical committees of the MASA are substantially in agreement with its findings."[45]

MASA's stance provoked a spate of resignations among its members most prominently that of Professor Stuart Saunders, then principal-designate of the University of Cape Town, and Professor Frances Ames, head of the Department of Neurology at the same university. In a 'letter to the editor' of the *South African Medical Journal*, Professor Saunders challenged MASA's Federal Council to state openly the implications of its position: namely, that medical doctors should acquiesce in decisions taken by the police and accept that there are considerations other

than the patient's welfare to be taken into account in treating a prisoner. Professor Gordon, in announcing his decision not to stand for re-election for the executive committee of the Federal Council after 25 years of service, characterised the actions of the Medical and Dental Council and the MASA executive committee in exculpating the doctors as "an act of impertinence and arrogance."[46]

The resignations and negative publicity eventually produced a response from MASA's Federal Council. Dr. Jonathan Gulckman persuaded it to form a committee to inquire into the ethical issues raised by the medical treatment of Biko. The Federal Council also agreed to approach the government on the matter of the medical treatment of prisoners, especially those detained under the security laws, and to establish a code of conduct for medical practitioners working under these circumstances.

In a statement to the press announcing these decisions, Dr. Gluckman expressed his personal distress at the position adopted by the Medical and Dental Council. He acknowledged, as a member of MASA's Federal Council, "that mistakes have been made by us in MASA in the handling of the Biko matter." Dr. Gluckman said that it was essential "in the public interest and in the interests of the reputation and the good standing of the medical profession as well as in the interests of the prisoners that these mistakes be rectified."[47]

The Ad Hoc Committee appointed to consider certain ethical issues (hereafter referred to as the ad hoc committee) reported to MASA in June 1981. Investigations by the ad hoc committee were limited by its lack of subpoena powers and the fact that Dr. Lang and Dr. Tucker did not participate in any of the committee's proceedings.[48] In addition, the police denied the ad hoc committee permission to examine the Walmer police station cells where Steve Biko had been held. The ad hoc committee's report, however, critically reviewed the available evidence concerning the doctors' conduct and openly disagreed with the findings of the Medical and Dental Council.[49]

The report of the ad hoc committee encouraged those doctors who were dissatisfied with the Medical and Dental Council's decisions. Five doctors subsequently lodged with the council a detailed series of charges and complaints concerning the conduct of Drs. Lang. Tucker, Hersch, and Keeley. Appended to the document was a list of sixteen cases, dating from 1974 through 1980, involving similar instances of improper or disgraceful conduct by medical practitioners, along with the sentences imposed by the council's disciplinary committees.[50] A month later, in March 1982, five other doctors, together with the Transvaal Medical Society (now the Health Workers' Association), a voluntary organisation of mostly black doctors and allied personnel, lodged a separate list of complaints against Dr. Lang and Tucker.[51] Both sets of complainants referred extensively to the full record of the inquest proceedings in detailing and motivating the charges against the doctors.

In March 1983 the Medical and Dental Council's inquiry committee met to consider the allegations. The inquiry committee resolved "that all material evidence which had been submitted in support of the present complaint had also been considered by the committee and the council previously, and that no new material evidence had emerged such as warranted the rescission of the council's previous resolution". Accordingly the inquiry committee resolved that no further action should be taken against the doctors. A month later the Medical and Dental Council confirmed this resolution, once again rejecting a motion proposed by Drs. Shapiro and Carlton to the contrary.[52]

Faced with this rebuff, the complainants were forced to seek Supreme Court review of the matter. They petitioned the Court to set aside the resolutions of the Medical and Dental Council and its inquiry committee, and to direct the council to hold a new inquiry into the allegations of improper or disgraceful conduct on the part of Drs. Lang and Tucker. The petitioners argued that it was in the public interest and in the interest of South Africa that the applicants' complaint be properly heard. "The international reputation... of medical practitioners within the Republic," they noted, "has been tarnished by the fact that the [council] had failed properly to get to grips with an inquiry into the conduct of the medical practitioners whose conduct is in issue."[53]

In January 1985 the Court ruled in the petitioners' favor. It found that the inquest proceedings did support the charges and complaints of the applicants, and that there was *prima facie* evidence of improper or disgraceful conduct on the part of Drs. Lang and Tucker. The presiding judge referred, *inter alia*, to Dr. Lang's false medical certificate which represented an apparent breach of one of the Medical and Dental Council's rules of ethics. The inquiry council and its inquiry committee, in concluding otherwise, had misdirected themselves. The Court also found that the applicants, as medical practitioners, did have *locus standi* to approach the Court, because the purpose of the 1974 Act governing the activities of the council was intended not only to protect the public vis-a-vis the medical profession but also the reputation of the medical profession itself.

The Court then issued an order repudiating the resolutions adopted by the Medical and Dental Council and its inquiry committee in 1983. It directed the inquiry committee to resolve "that the evidence furnished in support of the aforementioned complaints discloses *prima facie* evidence of improper or disgraceful conduct, or conduct which when regard is had to the respective professions of [Drs. Lang and Tucker] is improper or disgraceful." It further directed the council to establish a disciplinary com-

mittee to investigate the conduct of the doctors.[54]

After seven years of evading its statutory responsibilities, the Medical and Dental Council was now forced to hold disciplinary proceedings against the doctors. In July 1985 a disciplinary committee, chaired by the president of the council, held hearings for four days. The committee found Dr. Lang guilty of improper conduct on 5 counts in that it (1) had issued an incorrect medical certificate and a misleading letter; (2) had failed to examine the patient properly; (3) had failed to inquire into and ascertain the possibilities of a head injury; (4) had failed to obtain a proper medical history of the patient; and (5) had failed to observe him and keep proper notes. Dr. Lang, who intended to continue practicing for a further five years, was given a caution and a reprimand.

The disciplinary committee found Dr. Tucker guilty of improper and disgraceful conduct on 3 counts: (1) he had failed to object to the patient's transportation by a Land Rover to Pretoria; (2) he should have insisted upon transportation by ambulance with proper medical attendants and the patient's medical records; and (3) he failed to make a proper medical check before stating that the patient's central nervous system had shown changes between examinations. The committee suspended Dr. Tucker, who was due to retire shortly, for three months from the medical rolls, but recommended that the enactment of the penalty should be suspended for two years conditional on his not being found guilty by the council or any other contravention during this period.

MASA's secretary general Dr. Viljoen issued a statement welcoming the committee's judgment. Dr. Viljoen added that "as in the past the findings of the Medical and Dental Council were accepted by the MASA." The sentences, however, were strongly criticised by others as being "pathetically inadequate." Several months later, in October 1985, the council stripped Dr. Tucker of his medical qualifications.[55]

The failure of the Medical and Dental Council and MASA to respond quickly and appropriately to the allegations against the Biko doctors had resulted in a bitter international controversy concerning MASA's membership within the World Medical Association. In 1981 a number of national medical associations, including the British Medical Association, withdrew from the world body in protest over MASA's continuing membership. Throughout 1985, international pressure on the WMA, combined with a campaign inside South Africa by a broad range of medical and health groups, led the WMA to alter its plans to hold its next annual meeting in Cape Town.[56]

Amid this controversy over its international standing, MASA acknowledged that the "Biko case" had done irreparable harm to the South African medical profession. The association, however, maintains a defensive posture on the matter in its correspondence in professional journals, which has only deepened the growing polarisation within the South Africa medical community. During an interview in 1985, Professor Frances Ames, one of the petitioners in the Supreme Court case against the Medical and Dental Council, expressed her concern about "this polarisation amongst medical doctors." The formation of an alternative professional association, the National Medical and Dental Association (NAMDA), in 1982 concretely expressed the dissension within the medical community.[57]

During part of an exchange with MASA on ethical issues which was published in the *South African Journal of Human Rights*, Professor Trefor Jenkins, one of the applicants in the Supreme Court suit, urged MASA to admit that it had made errors of judgment in the Biko case. Professor Jenkins argued that doctors, like other members of the society, have been initimidated by the police and the repressive measures used to implement and maintain *apartheid*. It was his firm belief that "the Council (and to some extent the MASA) [had] allowed itself to be influenced by irrelevant considerations when discussing the case of the Biko doctors." The case was, he felt, "one of straightforward and relatively simple medical ethics but the two bodies in question [had] allowed political (and, perhaps, what they perceived to be state security) considerations to cloud the issue." No good would be served, he said, by MASA persisting in the view that it did all it possibly could to ensure that justice was done in dealing with the unprofessional and even disgraceful conduct of the doctors who cared for Biko." Professor Jenkins suggested that MASA intensify its efforts to restore the image of the profession to one in which all doctors could feel proud and in which the public could feel confidence again. In a situation of deepening conflict in the country, the medical profession, Professor Jenkins urged, must be prepared to censure unequivocally any doctor who fails to expose police brutality or torture, lest irreparable harm be done to the trust relationship existing between doctor and patient, and the practice of medicine become impossible.[58]

Notes

1 District surgeons and general practitioners employed by the Department of Health. Their responsibilities include the provision of medical care to prisoners under regulation 6 of the prison regulations promulgated in 1965 under Prisons Act 8 of 1959. About 26 localities in South Africa have full time district surgeons. Part-time district surgeons operate elsewhere. Interview with Mr. Filmalter, acting registrar of the South African Medical and Dental Council, by Eric Stover in Pretoria in December 1985; Gilbert Marcus, "Safeguarding the Health of Detainees," unpublished paper, Center for Applied Legal Studies, University of the Witwatersrand, April 1987, pp 6-9.

2 Biko had been detained on a number of occasions, including for a period of 137 days in 1975. He had also been subjected

to a five-year banning order. Concerning his life and political activities, see Hilda Bernstein, *No 46—Steve Biko* (London: International Defense and Aid Fund, 1978); Milard Arnold, ed, *Steve Biko, Black Consciousness in South Africa* (New York: Vintage Books, 1979); Gail M Gerhart, *Black Power in South Africa: The Evolution of an Ideology* (Berkeley: Unversity of California Press, 1978).

3 Quoted in Bernstein, *Biko*, pp 76-78; Complaint by the Transvaal Medical Society Against Doctors Ivor Lang and Benjamin tucker in terms of Section 41 of the Medical, Dental, and Supplementary Health Services Act, 1975, made to the South African Medical and Dental Council, March 18, 1982, pp 3-5.

4 An abnormal reflex after infancy characterised by extension of the great toe with fanning of the other toes on sharply stroking the lateral aspect of the sole, *Blackiston's Gould Medical Dictionary* (New York: McGraw-Hill, 1972), 3rd ed p 168.

5 Bernstein, *Biko*, pp 87-90; Complaint by Dr. Frances Ames and others involving allegation of improper or disgraceful conduct made to the South African Medical and Dental Council, February 17, 1982, pp 21-22, 31: Report to the Medical Association of South Africa by the Ad Hoc Committee appointed to consider certain ethical issues, June 1981, pp 3-4.

6 Complaint by Dr. Frances Ames and others, p 26.

7 Bernstein, *Biko*, pp 33, 90-96; Report to the Medical Association of South Africa, p 4; Lawrence Baxter, 'Doctors on Trial: Steve Biko, Medical Ethics and the Courts', *South African Journal on Human Rights*, Vol 1, Pt 2 (August 1985), p 139.

8 Bernstein, *Biko*, pp 62-63.

9 Report to the Association of Law Societies in South Africa by Sir David Napley, former president, British Law Society, in Bernstein, *Biko*, pp 137-147.

10 Quoted in Complaint by Dr. Frances Ames and others, p 2. Following the inquest verdict, the Attorney General declined to pursue criminal proceedings and the Minister of Justice announced that the appointment of a Police Board of Inquiry was not warranted. Baxter, 'Doctors On Trial', p 149.

11 *Veriava and Others v. President, South African Medical and Dental Council and Others*, 1985 2 (SA) 293 (TPD), p 297.

12 Letter addressed to the Natal Coastal Branch of the Medical Association of South Africa, quoted in Complaint by Dr. Frances Ames and others, Annexure C, p 3. (The letter was also reported in *The Cape Times*, November 26, 1989.) Professor Gordon supplied an affidavit to the same effect in a Supreme Court action in 1984 (discussed below).

13 Report by Dean Louis H. Pollack on behalf of the Lawyers' Committee for Civil Rights Under Law, in Arnold, ed, *Steve Biko*, pp 344-346.

14 Complaint by Dr. Frances Ames and others, pp 18-38; Complaint by the Transvaal Medical Society, p 2-13; Bernstein, *Biko*, pp 76-95, evidence of Dr. Lang.

15 Bernstein, *Biko*, pp 76-79, evidence of Dr. Lang.

16 Complaint by Dr. Frances Ames and others, p 23, evidence of Dr. Lang.

17 *Ibid*, pp 22, 24, evidence of Dr. Lang.

18 *Ibid*, pp 25-26, evidence of Col. Goosen; Bernstein, Biko, pp 76-78, evidence of Dr. Lang.

19 Bernstein, *Biko*, pp 76-78, evidence of Dr. Lang.

20 *Ibid*, p 88.

21 *Ibid*, pp 92-93, evidence of Dr. Tucker.

22 *Ibid*, pp 83-85; Complaint by Dr. Frances Ames and others, p 49.

23 Bernstein, *Biko*, pp 95-96; Complaint by Dr. Frances Ames and others, pp 40, 54-55, evidence of Dr. Tucker.

24 Complaint by the Transvaal Medical Society, pp 22-26; Bernstein, *Biko*, pp 92-93; Complaint by Dr. Frances Ames and others, pp 43-46, evidence of Dr. Tucker.

25 Counsel's submission on behalf of the Biko family, in Bernstein, *Biko*, pp 110-114.

26 Established in terms of Act No. 56 of 1974, the Medical and Dental Council's members include: i) The Secretary of Health; ii) Ten members appointed by the Minister of Health who has the power to overrule any of the council's decisions, iii) Nine designated members, including the Director of Hospital Services, five medical and dental practitioners from university faculties of medicine and dentistry and designated by the principles of those universities, and three persons designated by the College of Medicine of South Africa, the South African Nursing Council, and the South African Pharmacy Board; and iv) Fourteen members elected by medical practitioners and dentists.

27 South African *Government Notice* R2278 published in *Government Gazzettee* 5349 of December 3, 1976. Rule 25(2) prohibited the performance by medical practitioners and dentists of professional acts under impropre conditions and/or surroundings, except in an emergency.

28 *Veriava*, p 307.

29 Baxter, "Doctors in Trial," pp 140-141; *Veriava*, pp 297, 298.

30 The inquiry committee, created under Section 61(1)(a) of the 1974 Act, is appointed at the beginning of each year from the members of the Medical and Dental Council and is charged with the duty of conducting a preliminary inquiry into complaints.

31 The plaintiffs brought an action for R90,000 damages against the security police, Drs. Lang and Tucker, and the Ministers of Health and Police. In July the Biko family accepted an out-of-court settlement of R65,000 from the State. The Minister of Police denied that the settlement amountd to an admission of liability. Lawyers' Committee for Civil Rights under Law, *Deaths in Detention*, pp 67-68.

32 Judgment in *Tucker & Another v. South African Medical and Dental Council & Others*,, 1980(2) SA 207 (TPD), pp 298, 213; Baxter, "Doctors on Trial," p 151. Judgment was rendered in December 1979.

33 *The Cape Times*, November 26, 1980; *Veriava*, p 299.

34 Quoted in *Veriava*, p 299.

35 Professor Gordon withdrew from the proceedings because of his involvement in the inquest. A number of other council members were absent when the final vote was taken. *Veriava*, p 299; Baxter, "Doctors on Trial," p 142.

36 Interview with Professor Phillip Tobias by Eric Stover in Johannesburg on December 11, 1985.

37 Reported in *Nature*, Vol 286, No 5770 (July 1980), p 200; *The Lancet*, No 8205 (November 29, 1980), pp 1184-1185. See Appendix A for Declaration of Tokyo text.

38 Reported in *Nature* (July 17, 1989); Trefor Jenkins, "The MASA Letter: A Rejoinder, The Organised Medical Profession on Trial," *South African Journal on Human Rights*, Vol 2, Pt. 2 (July 1986), p 236; "Biko Saga: The Ethics of Suppression," in *Critical Health* (Johannesburg), No 3 (July 1980), p 48; *Survey of Race Relations 1980* (Johannesburg: SAIRA, 1981), pp 570-572. In contrast to its response to the charge against the Biko doctors, the Medical and Dental Council moved quickly to organise disciplinary proceedings against Dr. Aubrey Mokoape, after he had served six years in prison for contravening the 1967 Terrorism Act. According to Amnesty International, Dr. Mokoape was interrogated, beaten, and held in solitary confinement during his

detention in 1974. He was convicted of two counts under the Terrosim Act, after a long trial in which the State attempted to prove a link between the Black Consciousness movement and political violence. Not a single act of violence was proved against any of the defendants. Two years after his release from prison Dr. Mokoape was informed that the Council's Medical Committee of Preliminary Inquiry had resolved that there was a *prima facie* case of improper or disgraceful conduct against him. The charge against him, relating solely to his conviction under the 1967 Act, represented the first occasion in which the council used a political conviction as ground for a disciplinary inquiry. One of the applicants in the Supreme Court suit initiated in 1984 against the council and the Biko doctors. Dr. Yosuf Veriava, attended the initial council hearing which he later described as making the council appear to be "an extension of the South African repressive machinery." The council eventually dropped the case after Dr. Mokoape's lawyers challenged the proceedings on technical grounds. Amnesty International, *Political Imprisonment in South Africa*, pp 59-60; summons issued against Dr. Mokoape by Mr. N. M. Prinsloo, Council Registrar, November 6, 1984; *Sunday Express*, January 13, 1985; *Sunday Tribune*, January 13, 1985; interview with Dr. Jerry Coovadia by author in Washington, D.C. on June 23, 1987.

39 *The Argus* (Cape Town), October 1, 1980.

40 According to Dr. Stuart Saunders of the University of Cape Town, about 70 per cent of the country's medical doctors are members of MASA. Dr. Jonathan Gluckman put the membership of MASA at between 10,00 and 11,000. Interview with Dr. Stuart Saunders by Eric Stover in Cape Town on December 14, 1985; interview with Dr. Jonathan Gluckman by Eric Stover in Johannesburg on December 9, 1985. Of 16,815 medical doctors in South Africa in 1983, 15,251 were white, 60 2343 'colored', 1,255 were Indian, and 249 were African (Department of Manpower figures for April 1983, quoted in Dr. M. Ramphele, 'Health and Social Welfare in South Africa Today', unpublished paper presented at AAAS annual meeting, Philadelphia, May 25, 1986, p 6).

41 Baxter, 'Doctors on Trial', p 142; private correspondence, Dr. Viljoen to Prof. S. J. Saunders, November 27, 1980.

42 Private correspondence, Dr. Viljoen to Prof. S. J. Saunders, November 26, 1980; Report to the Medical Association of South Africa, 1981, pp 7-8; *South Arican Medical Journal* (September 13, 1980), p 433.

43 Statement by the executive committee of the Federal Council, MASA, regarding the conduct of the doctors responsible for the treatment of the late Mr. S. B. Biko, in *South African Medical Journal*, (September 13, 1980), p 433.

45 The chairman of MASA's Federal Council, Prof. J. N. de Klerk, described the *SAMJ* as the "official organ and mouthpiece of MASA" which "must reflect the Association's policies," in a letter to Professor Stuart Saunders, November 27, 1980.

45 *South African Medical Journal*, (September 13, 1980), pp 432-433.

46 Letter to the editor of the *South African Medical Journal*, (September 17, 1980). Professor Saunder's letter was neither published nor acknowledged by the editor, although it appeared in full, without author's permission, as an agenda document for the Federal Council meeting of November 12, 1980. Private correspondence, Prof. Saunders to chairman of the Federal Council of MASA, November 14, 1980. Complaint lodged by Dr. Frances Ames and others, Annexure C. Apparently the journal editors also refused to publish the Witwatersrand Medical School statement on the case. Interview with Prof. Phillip Tobias by Eric Stover in Johannesburg on December 11, 1985. In the interview, Prof. Tobias criticised the then leadership of MASA for "dragging its heels in subservience to the government."

47 Press statement by Dr. Jonathan Gluckman, November 19, 1980.

48 The authors of the ad hoc committee report claimed that the Deputy Director of Health Services forbade the doctors' involvement in the proceedings. The Assistant Secretary of Health Services, according to Prof. Saunders, argued "why should my district surgeons take up rap for the police." Interview with Professor Stuart Saunders by Eric Stover in Cape Town on December 14, 1985.

40 Report to the Medical Association of South Africa by the Ad Hoc Committee appointed to consider certain ethical issues, June 1981; Baxter, 'Doctors on Trial', p 142.

50 Complaint by Dr. Frances Ames and others (see note 39). The complainants were Dr. Frances Ames; Dr. Edward Barker, senior surgeon, University of Natal Medical School; Dr. Trefor Jenkins, head of the Department of Human Genetics at the University of the Witwatersrand; Dr. Leslie Robertson, a medical general practitioner; and Dr. Phillip Tobias, dean of the Faculty of Medicine at the University of the Witwatersrand. Baxter, 'Doctors on Trial', p 142; *Veriava*, p 299.

51 Complaint by the Transvaal Medical Society and others (see note 37). The individual complainants were Dr. Dumisani Mzamane, head of the Renal Unit at Baragwanath Hospital; Dr. Yosuf Veriava, a senior physician at Coronation Hospital; Dr. Rasik Gopal, neurosurgical registrar at Baragwanath Hospital; Dr. T Wilson, a pediatrician; and Dr. E. Holland. *Veriava*, p 30.

52 Baxter, 'Doctors on Trial', p 143; *Veriava*, pp 301-303.

53 Court papers in *Veriava*; Baxter, 'Doctors on Trial', p 143.

54 *Veriava*, pp 311-318.

55 Baxter, 'Doctors on Trial', pp 150-151; *South African Medical Journal*, Vol 63 (August 3, 1985) p 131; *The Lancet*, No 8447 (July 20, 1985), p 136; *The New York Times*, July 6, 1985; *The New York Times*, October 17, 1985.

56 Baxter, 'Doctors on Trial', pp 150-151; *Survey of Race Relations 1985* (Johannesburg: SAIRR publication, 1986), pp 454-455; *The Lancet*, No 8462 (November 2, 1985), pp 1000-1001; *The Lancet*, No 8424 (February 9, 1985), pp 342-343; *Canadian Medical Association Journal*, Vol 130 (June 15, 1985), pp 1623-1624; Memorandum submitted to the World Medical Association by the National Committee of Health Organisations, South Africa, June 1985.

57 *The Lancet*, No 8462 (November 2, 1985), pp 1000-1001; *The Lancet*, No 8430 (March 23, 1985); *British Medical Journal*, Vol 292 (February 22, 1986), p 506; *JAMA*, Vol 254, No 22 (June 12, 1987), pp 3066-3067; interview with Professor Frances Ames by Eric Stover in Cape Town on December 17, 1985. Some 60 per cent of NAMDA's current membership of 1,000 doctors and dentists are black. The new association was created partly in reaction to MASA's behaviour over the Biko case and partly as an expression of concern about broader health issues which NAMDa members felt MASA was not properly addressing. Dr. Diliza Mji, 'The struggle for Health: The Struggle for Democracy', unpublished paper presented at the Institute of Social Studies, Amsterdam, December 1986; Memorandum submitted to the WMA by the National Committee of Health Organisations (including NAMDA), June 1985; interview with Dr. Jerry Coovadia by the author in Washington, D.C. on June 23, 1987.

58 Jenkins, 'The MASA letter', pp 234-240.

In Defence of Civil Rights

A Biographical Sketch of Dr Ramanadhan

A doctor who renders help to political activists often comes into conflict with oppressive state apparatus and is himself a target of repression. Dr Ramanadhan's life and death exemplifies this. He was a civil liberties' activist, a human and rational doctor's who fell to a police bullet in Warangal in September 1985. This sketch is reprinted from an anniversary tribute to him published by the P U D R New Delhi.

MUSTIKUNTALA is a village in Mahira taluq, Khamamam district that separates the Telengana from the Andhra region. In the thirties the village had a small population of about three hundred, subsisting on cultivation of dry and barren land. But now the village has become prosperous thanks to canal irrigation and even has a high school.

It was in the village that Dr. Ramanadhan was born on October 16, 1933, third son of Anatarama Rao and Rajyalaxmi. The family had about 30 acres of dry jowar land. Ramanadhan was the first person in the family to insist on higher education and had to struggle his way to become a doctor. He completed his primary education in the village and did his secondary school is nearby Khammam. Despite family oppostion he went to C.R. Reddy College, Eluru for his intermediate, and then to the famous Nizam College, Hyderabad, for his B Sc. degree. During his Nizam College days he become part of a group of students who were peripherally associated with the All Hyderabad Students Union. The house of Dr. Balachandra Paranjpaye, well-known veteran of the Telengana struggle, was the cenre for all young men in those days. Dr. Paranjpaye remained a source of guidance to Ramanadhan all his life.

After his B.Sc he took up a number of irregular jobs for more than a year, which included teaching and a job as a medical representative. Around this time he also got married. Then he got admission in M.B.B.S. in the newly-established Gandhi Medical College, Hyderabad. Financially, these were his bad days, having to live on the limited amount sent by father and his house surgeonship. He joined Osmania College for his Diploma in Child Health. It was during this period that he became a student of the famous left wing intellecual, Dr. Rajagopalan. Both were to work together, twenty years later, in the APCLC. Throughout his student career he remained on the periphery of then student movement. In fact, later on too he never became part of any organised political group.

After completing his studies he joined government service. First he taught in Kakatiya Medical College and worked in Mahatma Gandhi Memorial Hospital where he was to die later. Then for over four years he worked in the listless primary health centers at Chityala, Vangara and Husnabad in the Warangal and Khammam districts. Primary health centres then and now are private clinics for those who weild social power in the village and not clinics for the people. Invariably Ramanadhan could not adjust himself to work in this kind of framework. Husnabad became his last job.

Husnabad, a taluq centre, is a big village with around a population of 10,000. If Health Centre serves a number of the neighbouring villages. The earlier doctors and compounders had established a routine pattern of corruption. They did not attend the centre, but used the medicines and equipment of the centre to run their own private clinics. When Ramanadhan took charge, he put an end to this practice. This earned him the warth of the compounder, the Block Development Officer, and the Samiti president who all used to share the booty. But Ramanadhan struggled against these forces and became a very popular doctor. Eventually things came to a head when he was asked to issue a death certificate for an unidentified young girl in the house of the Samiti president. The doctor refused. And soon after, he resigned from government service.

He set up his own children's clinic on Jayaprakash Narayan Road, Warangal, in 1968. He was the first pediatrician in the town and soon became very popular. It was from this period that he consciously engaged himself in social activities outside his profession.

In the early seventies, before the APCLC was formed, he became a kind of supportive centre for a number of people involved in a variety of problems and issues. He helped his friends run a monthly that became a well known non-commercial journal in Telegu, *Srjana*. In fact, be it a writers' organisation wanting to hold its first meeting in Warangal or a young couple facing family opposition to their marriage every one sought his help and received it. In a dramatic incident he rescued a young girl and conducted her marriage. The girl's parents were influential people with powerfull connections. In the midst of the marriage function, the police arrived and arrested the bridegroom and his friends, on charges of abduction. Eventually the girl won her battle in court.

In early 1974, along with another well-known doctor of Warangal, Dr. Amjad Ali Khan, he became a founder member of APCLC in Warangal. Around the same time, he also organised a polyclinic in Warangal. When emergency was declared in 1975 all activities ceased. The General Secretary of the APCLC, advocate Prattipati Venketewarli was among the first to be arrested. Ramanadhan was also arrested, which led to the closure of the people's clinic, virtually the only democratic activity in the town at that time. He was taken to the illegal camp

maintained by the police at Pakala reserve forest.

Pakala is a wild life sanctuary where two bungalows meant for tourists were turned into police camps during the emergency. A number of young people arrested during the emergency were detained here and tortured. Among them was the sole eye-witness to the Girapalli encounters in which four young men were shot dead in cold blood by the police. Dr. Ramanadhan, who was a fellow detainee of the eyewitness, as to be of crucial assistance to the Tarkunde Committee which brought out its famous report on these encounters after the emergency. He was shifted after three weeks detention at the Pakala camp to Warangal Central Prison, which serves as the main prison for five north-western district of Telengana.

After the lifting of emergency, the central government appointed the Shah Commission of Enquiry which managed to submit its report, although no action was taken on it. Any one who has gone through the reports of the Commission can see that the largest number of crucial affidavits to the Commission from Andhra came from the Warangal region. Again, the aborted Bhargava Commission, which was appointed to enquire into encounter killings in Andhra, was helped by the mobilisation of crucial witnesses. In both instances, Dr. Ramanadhan played an unobtrusive but significance role.

In November 1977, a tidal wave hit Divi Seema in the Krishna district on the east coast. It led to hundreds of villages being marooned and to the death of thousands of people. Ramanadhan and his team was the first team of doctors to enter the inundated areas, before any government organisations or voluntary agencies. Later the team came back, raised funds, medicines and material necessities and went back to the flood affected areas and held a mobile medical camp for a month.

In late 1979, the junior doctors in Warangal along with their colleagues in the rest of the state went on a strike for over seventy days. The government attempted to suppress the strike at one level by repression and at another level by generating a mass hysteria against the striking doctors. Dr. Ramanadhan took the initiative and organsied a people's clinic opposite to the government hospital with the help of the doctors on strike. The clinic became a centre for both the medical service and the strike. The ramshackle pandal outside the hospital became so popular that poor people requested the dcotors to continue the clinic even after the eventual withdrawal of the strike.

In an unusual incident, Dr. Ramanadhan assited a Brahmin widow whose husband had been the priest of a temple. After his death the widow managed the temple. But the trustes rejected her, presumably because of the land value of the temple, on the ground that a woman cannot be a priest. APCLC Warangal, under Ramanadhan, took up her case and eventually won the battle for her and also set a precedent.

What earned him the wrath of the Warangal police was systematic efforts by the APCLC to expose the lawlessness of the police. Hundreds of illegal arrests, torture, setting up of armed police camps in villages and colleges alike have become routine in past years. Since 1983 at least 12 people were killed in either police lock-up or in so-called encounters. In Warangal district, the APCLC investigated each of these instances and brought police violence to the notice of the public. In a number of cases it provided legal help to the victims of police harrassment. It challenged the constitutional validity of the armed camps in the colleges and villages of Warangal. As the APCLC steppted up its campaign, it has become a fetter on the arbitrary behaviour of the Warrangal police establishment.

Initially the police began with a systematic campaign that APCLC was a extremist front organisation. APCLC's own diversified activities was projectd as an organisation that is working in the interests of extremists. Later, APCLC activities began to be implicated in false cases. In 1984, two of the activists were implicated in a case of obstructing police from discharging their duty. The case was later dismissed.

In January 1985, Dr. Ramanadhan was arrested along with Dr. K. Balagopal and K. Seetarama Rao. They were charged with, among other things, distributing arms to the extremists. The doctor was released on bail a week later. While he was in police lock-up, in a telling incident, the policemen who had arrested him brought his child for treatment to the doctor. The incident indicates the extent to which he had become popular, even among the policemen of Warangal.

Dr. Ramanadhan's social awareness helped him to understand the social origins of the diseaes of his patients. He did not confine himself to giving medicines but tried to spread a scientific outlook. It was in this process that he wrote the famous book *Medical Guide* (in Telugu) which was addressed to the people and not to the health workers. The book became very popular. A second edition came out within an year and now, after his death, a third edition has been printed. Even after establishing himself as a popular doctor, his interests in studies remained. He took part in different seminars and meetings of the profession. A few weeks before his death he participated in a conference held at Nizam Orthopedics Institute. This professionalism was to remain with him till the very end. In the last twenty minutes of his life en route to the hospital, he kept discussing with the young doctor, who took him in his car, the diagnosis of his injuries and suggesting treatment.

In a sense his involvement with his profession helped the civil rights movement which in turn made him a better doctor. He was a doctor not only to rickshaw pullers, hawkers, and slum-dwellers but also to the policemen and their children. A few days before his death, an SI who

was leaving the town on promotion came to him and gave him sweets by way of farewell. The SI is believed to have said that for Warangal police he is not only a civil rights activists but also a doctor. Ramanadhan accepted the sweets with the confidence in human relationships which he had built over sixteen years of service to his patients and to the people of Warangal. Evidently the policemen who killed him did not share such values.

But perhaps his patients, people for whose lives he had fought and whose rights he had defended shared them. That is why on September 4, defying Section 144 and undeterred by the presence of armed police, they came in their thousands and paid their respects to the man who fought for them. His life and death will remain a defiant celebration of human values and a never ending source of inspiration for the democratic movement.

Aftermath

The news of Dr. Ramanadhan's death reached Delhi on the morning of September 14, 1985. Two prominent Delhi dailies carried a report, field by a national news agency, that Dr. Ramanadhan, vice president of the APCLC was killed by 'extremists' in his clinic on the previous day. In fact no correspondents of this news agency, which does not have a Warangal office, were present in Warangal on September.3. The report was filed from Hyderabad, within two hours of the incident. All other stae-level and local dailies carried reports by their Warangal correspondents saying that the doctor was killed by armed policemen accompanying the dead body of SI Yadagiri Reddy.

Next day, the superintendent of police, Warangal, contradicated the local newspaper accounts and stated that Dr. Ramanadhan was possibly killed by some extremists. When eye-witness journalists pointed out that uniformed policemen were seen entering Dr. Ramanadhan's clinic, he stated that they had gone to the rescue of the doctor. On the same day, Vasant Nageswara Rao, home minister, made a statement on the incident in response to a notice under rule 329, tabled by 23 memebrs in the state assembly. The home minister maintained that the suggestion that the police were behind the incident was 'baseless'. He added that the incident took place long after the funeral procession of armed police had left the place. He also indicated the involvement of extremists factions in the murder. Meanwhile APCLC had released its own report on the incident.

The postmortem report, quoted by the APCLC, states that the death was caused by a service revolver fired at point blank range. On that basis and other corroborative evidence APCLC demanded the immediate susupension of the senior police officials and ordering of a judicial enquiry. The government refused to hold a judicial enquiry. Instead a CBI CID enquiry was ordered. A few weeks later the government suddently discovered that two policemen were guilty of dereliction of duty. They had let their service revolvers be stolen from them two months prior to the incident! Presumably the stolen revolvers were to be traced to the 'extremists' who somehow became part of an armed police procession and killed the doctor without anyone ever noticing it.

Meanwhile police claimed to have identified the six people who were involved in the Yadagiri Reddy murder case. The case itself was brought under the Terrorist and Disruptive Activities (Prevention) Act, 1985 which came into effect in Andhra Pradesh from August, 1985. This was the first and the only murder case so far under the act in the state. Two of the accused, Nageswara Rao and Ramakrishna, were killed in a so-called encounter in April this year. The other accused include Dr. K. Balagopal general secretary, APCLC, who was let out on bail and Dr. P. Varavara Rao, general secretary of the Revolutionary Writers Association, who is still in jail.

Eventually the CB CID enquiry did take place. An SP who was till recently in the Andhra police was deputed for the enquiry. He visited Warangal in late October for three days and submitted the report to the government. It has not been released to the public or even to the assembly so far. But we understand that the report came to the conclusion that the "assailants remain unidentified".

Why Are Torturers Never Punished?

Case of Archana Guha

peter vesti

Archana Guha was arrested in July 1974 and subjected to 27 days of torture in the hands of the police. She was not charged formally but was made to believe that the arrest was because of her association with the Naxalite movement. After her release a physically shattered Archana filed a case against her torturers which has yet to be decided upon. This article was first published in the Danish Medical Bulletin, *1988.*

UNTIL recently, little was known about the various aspects of symptomatology or about treatment of torture victims. At the Rehabilitation Centre for Torture Victims in Copenhagen (RCT), over the past five years we have treated torture victims and compiled information about the essential aspects of treatment of these most unfortunate human beings.

These experiences have made it increasingly clear that the end-purpose of torture is to 'break' the person, i.e. to transform a formerly healthy member of society into an individual broken in spirit and unable to function efficiently in any aspect of personal or public life. An appalling insight by the torture victims is that the vast majority of people are indifferent about what has happened to them; even more horrifying is the undrstanding that the torturers continue to perform whatever duties they are assigned (perhaps including torture) and are never brought to justice, often in spite of a change of national regime or the election of new political parties.

This has been seen in various places and at various times in the world. International attention has focused on the very limited trials of only a few of the accused torturers in Greece after the fall of the military government [1], the strange circumstances surrounding the death of Steve Biko in South Africa [2], and the impotence of the newly elected government in Argentina to deal with criminals who were torturers under the former military junta [3].

A case that will illustrate such occurrences is the story of Archana.

In 1980, an Indian national by the name of Archana Guha was flown to Copenhagen to receive treatment at Rigshospitalet, one of our University Hospitals. Thrity-nine years old, she arrived on a stretcher, had years before been tourtured, and was now suffering the consequences. With the help of Amnesty International, she was transferred to Denmark to receive treatment at the centre later to be developed into the Rehabilitation Centre for Torture Victims (RCT). Following is a review of the circumstances of the case and the sad recognition that now, many years later, Archana's case against her tortures is still pending before the court in Calcutta.

The early 1970s were a violent time in West Bengal. A militant Marxist grouop, the Naxalities, were ravaging the countryside, and many people were caught inthe crossfire between it and a government using all means to fight it. One such person was Archana Guha. Educated as a school teacher, in 1967 she was appointed. head mistress of Kolorah Girls Junior High School outside Calcutta.

Arrest and Torture

On July 17, 1974, Archana was arrested in the middle of the night together with her sister-in-law and a friend staying in the house. No formal charges were brought against them, but they were made to believe that their arrests were due to some connection with the Naxalite movement. The matter was never brought to court.

Twenty-seven days of torture followed at Lalbazar, headquarters, of the Calcutta police. First, Archana was made to witness the assault on and torture of her sister-in law and her friend. She was then tied, hands and feet, slung upon a pole, head down, and severely beaten on the feet (falanga). The five policemen involved took turns hitting her and kicking her on the hips, and later they burned her toenails with cigars. She was threatened with rape and made to understand that her family would also be tortured if she did not cooperate. When she was not in the torture chamber, she was kept in a small, dark isolation cell. During the torture she was forced to sign several blank papers. She was suspended by her hair and, later, 'brain washed'—a term used by torturers for a procedure in which they begin a movement to bang her head against the wall, but at the very last moment before her head struck the wall, pull her back.This was done 10-20 times.

It seems likely that the three women were arrested because of Archana's brother Saumen. He was also accused of involvement with the Naxalite movement. He was arrested on the August 6, 1975, and when Archana's torturers learned of his arrest, they stopped torturing her. Saumen, himself, was allegedly on two occasions subjected to torture for periods of six and 14 days.

Archana never came before a judge, even though the law specifically states that this must take place within 24 hours of the arrest. On August 13,1974, Archana was brought to the Presidency Jail. In September 1974 she was released, but immediately after was again detained under the Maintenance of Internal Security Act (MISA). She was

released on parole in November 1976 and on May 3, 1977 was also released from MISA detention. The Left Front (a coalition of left wing parties) was now in power in West Bengal.

After the torture, Archana had multiple symptoms. She suffered headache, swelling around the left eye, a burning sensation in the head, difficulty breathing, irregular periods as well as bleeding from the rectum. She suffered several infections in the urogenital system. She also suffered difficultly sleeping, had no appetite, and poor concentration.

Her condition deteriorated, and gradually she lost muscle strength in her arms and legs, grew weak and also lost sensation. She was confined to bed and to a wheelchair. From December 1975 to February 1976, she was hospitalised in the SSKM Hospital—was under round-the-clock police guard—but did not improve. She was later transfererred to the Medical College Hospital, still under police guard, still paralysed, and was told that she could expect no major improvement. An X-ray at that time showed a fracture of the seventh cervical vertebra.

Upon arrival in Denmark four or five years later, Archana was still suffering from a number of symptoms. She had constant headache, nausea, and muscualar pain in the neck and shoulders. She was constipated and slept poorly, suffered tremous, and was still unable to concentrate. She was mostly confined to bed, being unable to walk without human support.

Neurological examination showed a decrease in strength in the arms which were also somewhat atrophic. Her legs showed a decrease in strength bilaterally, both for flexion and for extension. Both legs were atrophic. The patient was unable to walk unless supported by two persons. The reflexes could not be elicited.

Examination of the skin revealed several scars and pigmentation changes compatible with the history of combustion and subsequent ulceration. The size of the scars were in accordance with the size of a scar caused by the glow of a small cigar. The patient also described pustulations and alopecia as well as discoloration after being suspended by her hair. This is also in accordance with known sequelae to traction alopecia.

Beyond doubt, most of the patient's symptoms and signs are the result of torture. It is equally clear that poor conditions in the prison (possibly a deficiency in protein) as well as the depressing effect of prison conditions in general and uncertainty about the future, sustained and possibly aggravated Archana's condition.

In August 1977, soon after she was released, Archana filed a petition accusing five policemen of having violated relevant sections of the Indian Penal Code. At that time, she was unable to walk and had to be carried to the courtroom to make a personal appearance. The accused were: Ranjiit Guha Neogi (Runu), officer in-charge of the investigation; Santosh De; Aditya Karriaka; Arun Banerjee; and Kamal Das, alias 'the golden hand', known for being able to make most people talk under torutre.

Archana also requested a reasonable compensation for almost three years in jail and was offered a few hundred rupees. The authorities would not even bear the expense for her treatment at a major private clinic in Calcutta. With the help of Amnesty International and human rights groups as well as women's groups in India, attention was focused onthe case. Finally, the government in West Bengal agreed to pay the expenses involved in transferring Archana to Rigshospitalet in Copenhagen.

After intensive treatment, rehabilitation, and physiotherapy, Archana's health improved and gradually she was able to walk again. She later returned to India. While under treatment, she became painfully aware that her torturers in no way were affected by her petition and that the authorities apparently did not believe her and wanted the whole thing to be forgotton. We believe this influenced her rehabilitation negatively. During her stay in Denmark, she had made the acquaintance of an employee at Rigshospitalet, and Archana later moved back to Copenhagen to settle permanantly.

And what happened about the court case submitted in August 1977? Nothing much, I regret to say. None of the accused officers have been suspended. Death certificates have been produced for two of the accused (Aditya and Arun). Kamal Das (the golden hand) has disappeared and records seem not to indicate that he was employed by the Calcutta police in the first place. Every legal loophole has been used and abused to prolong the proceedings at the court. The accused have claimed that Archana's lawyer (A. P. Chatterjee) could not represent Archana because he was also the government's standing council. This was put to the high court as well as the Supreme Court twice before the legitimacy of his representing the client was confirmed. It appears that the evidence was misrepresented and the court misled the first time.

During the 1980s several human rights organisations and women's organisations followed the case and even demonstrated outside the court room—not for a verdict of guilt, but only for a speedy trial. Because of this, the accused filed a petition asking that these organisations be tried for contempt of court and that reportage of the trial be prohibited. The local magistrate did bar the newspapers from publishing the evidence of the witnesses. However, this was not abided by and was rejected by a higher court.

Aggrieved by the above-mentioned decision of the local judge, a new petition was filed by the accused requesting the transfer of the case to a new magistrate. And finally it appears that a new petition has been filed asking for change of judge as well as the place of trial. In addition to these obstacles. the accused have repeatedly requested

stay orders for various reasons, making it almost impossible for Archana to go on with the cse, considering that she is living abroad.

Conclusion

Ten years have lapsed, the case lingers on and still no verdict is insight. At the end of the 1970s many cases were brought against the police for torture; however, all other cases have been dropped. Very few people can keep a court case going for years; the legal expenses involved are astronomical. A very storng personality is needed to go through these ordeals with so little hope of success.

Archana's lawyer has taken on the case on a humanitarian basis. He, himself, has been threatened on many occasions and threats have also been made against his family. The whole court case seems to be a clash of interests. However, it is difficult to see who the accused party represents. Very expensive lawyers have been helping the accused (and prolonging the court case) all these years, and a question has been raised as to who pays their fees. In whose interest can it be to suppress a court case like this, to keep it from reaching a verdict?

If it had not been for support from internatioinal organisations, local human rights groups, and women's organisations as well as the press and television, this case might also have been dropped years ago. This would not be in the interest of a democratic country like India, where torture is prohibited by law.

In this context, we must also consider the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment (4), the United Nations convention prohibiting torture and setting up rules and regulations concerning international aspects of torture. So far, 43 states have signed the document, and of those, as of December 1987, 17 have ratified it. India has not yet signed this document, whose aim is to help progressive authorities bring about justice.

Archana was forced to spend three years of her life in prison, was brutally tortured, and only after intensive rehabilitation has been able to begin to live a reasonable life again. Three years of a lifetime is a long time. Cases of tortures being convicted and punished are virtually nonexistent as are cases of compensation paid out to the victims. More than three weeks of torture cannot be undone; three years of a life cannot be given back. The duty of society must be to compensate at a realistic level as well as to use such occasions to better it control over and insight into various services in our society, including the police. We must remember that the police force reflects that society in general. The time has come to recognise torturers as the criminals they are.

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State Torture: Some General, Psychological and Particular Aspects

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State political torture has been practised in Latin American countries and is well-documented. What are the particular aspects of this practice? What are the elements which contribute to a person participating in torture? Who is the real torturer?

WE may describe torture as that extreme and deliberate form of violence inflicted upon a victim who experiences it consciously, and who has no control over its form or duration. It produces pain and mental or psychologial stress and is intended to destroy the victim's will in an attempt to perpetrate a determined order of power relationships. When such practice is structured into the ways a state governs over the people of a nation, we may refer to it as state torture; but when the primary target is the citizens who oppose, or are believed to oppose, the order of relationships established by that state, we may talk of state political torture. In the American continent the use of torture as an identifiable administrative policy has been recognised in several countries [1-4], but the cases of Chile, Uruguay, Argentina, Paraguay, El Salvador, and Guatemala have become exemplary over the past ten years [1, 5-9]. In these countries thousands of citizens who oppose their governments have been (and are being) tortured in semi-clandestine torture centers, where similar methods and techniques of suffering are implemented. The subjects for torture are identified and selected by branches of the military and then kidnapped by "heavily armed men dressed in civilian clothes" who operate with impudent legal immunity. The victims are then taken to camouflaged jails where a minority of those who enter are able to come out alive to tell the story.

What is the purpose of such torture? On first hand it may seem that the answer is information. But if we review the methods and understand that in these countries torture has been made a stable semiclandestine institution of the state, its primary purpose can no longer be considered simply to secure information or a confession. How could we believe information is the aim when pregnant women are burned in the nipples and genitals and then receive electric shocks in the uterus producing either abortion or brain lesions in the fetus [3]? Or when splinters are inserted into the eardrums? And besides the cruelty *per se*, how valid could a confession be under those circumstances or under the effects of stupefacients? No, here the specific purpose served by such brutality seems to be primarily the destruction of the individual in his/her most basic humanity, while the general objective seems to be the attempt to preventing dissidence—a way of exercising and maintaining power by terror.

By definition, torture assumes the involvement of at least two subjects: the torturer, who applying torture strives for maximal submission of the victim under his physical control, and the victim, whose actual circumstance makes an immediate defensive counterviolence impossible. In the following sections, I will examine some aspect of the methods of torture, the torturer and the effects of this practice.

Methods of Torture

When torture is part of the state policy, the methods for destroying the morale and physical integrity of the victims are ample. Breaking down the victim, whether by producing an organic impairment of the mental functions [10] or by the effects of stress [11, 12], is achieved by the use of both rustic and sophisticated methods and techniques. What, when and how to torture is something established by accumulated local and international experience. Not infrequently, it is assisted by modern medicine and research findings, even with direct participation of physicians [13-21]. There are testimonial reports of medical doctors supervising the process of torturing, or monitoring the procedures so that unconsciousness and death are avoided while maximum stress is applied [1].

The scientific approach to torture has been taken seriously by some. In a recent article published in the *Journal of Medical Ethics*, 'On the Permissibility of Torture', G. E. Jones argues in support of torture [22]. Justifying it on utilitarian grounds he states:

> It (torture) cannot involve death, and must utilize the most advanced medical techniques available so as not cause needless psychological or physical harm. Only the minimal amount of pain necessary to obtain information would be inflicted (italics added).

And further, in a clearly marketing way, while discussing the cost-benefit ratio of torture (which he compares with solar energy: it pays in the long run) and under what he calls humane (sic) torture, he goes on saying that:

> The state of technology is such that we can stimulate certain centers of the brain such that we can inflict pain without physical abuse or *physical side effects*. (italics added)

The mode of torture that Jones proposes, which apparently includes electro stimulation or microsurgery to affect brain centers, selectively ignores that torture is terrible as an experience and not only for its visible sequelae. What Jones seems to be concerned with is the public or

observable evidence that torture had taken place, rather than what it represents, or the damaged self and relationships the torture victims are rendered with. Torture is a devastating experience that accompanies the surviving victim the rest of his/her life, affecting, as I will explain later, more than the physical or physiological aspects. Jones' statement that, "Only the minimal amount of pain necessary to obtain information would be inflicted" is naive. Would't a torturer ever accept having inflicted pain in excess of that necessary to his victims?

The pain and the stress caused by different methods of torture need to be multiple, variable and unpredictable. This way the victim's attempts at behaving in consistent ways or developing personal behaviour patterns to better sustain the suffering are frustrated. The methods and techniques of torture are often the same in the six Latin and Central American countries (Table 1), even to the point that many types of torture receive the same name (Table 2)—a case of internatioinal cooperation.

The catastrophic existential event that torture represents for the victim will certainly leave a permanent stigma in the survivor and his/her basic social nucleus. How, and to what extent, the terror, humiliation, loss of dignity and physical suffering will mark the victim is something that cannot be generalised. The structural characteristics of the victim's personality are important: the victim's clarity and strength of morale, sense of purpose and comradeship and even hatred of the system that brings the suffering [21]. But the effects of torture on the victim will also depend upon the dose of experienced violence, that is, the duration and intensity of the stressor.

The extent of the injury should be measured not ony by the bodily deformity or loss, or impairment, but by the emotional significance attached to the experience which often leads to a radical alteration of the person's whole life [23, 24]. Torture results in anxiety, difficulty in thinking, loss of self-esteem, social withdrawal, decrease in productivity and abandonment of goals [1, 14, 23]. For those who can no longer resist and who broke down, additional guilt and despair awaits.

From a psychiatric point of view, torture represents a situation of massive stress which unequivocably provokes anxiety, brought about not only by pain and mortifications, but also by uncertainty. Under torture, the threat of destruction is more than an imminent possibility—it has already started. Yet what the victim lacks is access to knowing how, when or if the destruction is going to be completed. In psychiatric language, the symptomatic post-effects of torture, together with other psychological traumatic events of inordinate nature and outside the usual human experience, fall in what are called post-traumatic stress disorders [25]. Briefly, these disorders constitute a condition that results in the contraction and disorganisation of the ego [26], hence to a symptom complex, acute or chronic characterised by: 1) recurrent and intrusive recolections of the traumatic event and nightmares in which the event is re-experienced as it was or in a representational way; 2) dissociative states that last from minutes to days, in which the individual behaves as if the trauma were recurring, because of an association with an environmental or ideational stimulus that elicits them; 3) constriction of affect, reduced responsiveness to the surroundings, and feelings of estrangement from others; 4) hyperalertness, exaggerated startle response, sleep disturbances, memory impairment, etc. Yet, as has been observed, the symptoms brought forth by deliberate man-made disasters, such as torture, often exceed other stressors in severity and consequences and may even precipitate premature death [27].

Table 1: Methods of Torture[a]

1. Environmental Manipulation:
   - Social deprivation (isolation from family and friends)
   - Isolation (restrictionof company, sex, work, relaxation, food)
   - Sensory deprivation or overload (solitary cells, noises, reflectors, etc.)
   - Sleep deprivation
2. Pharmacological Manipulation:
   - Parenteral barbiturates and stupefacients
   - LSD and related drugs
   - Apomorphine
   - Corrosive chemicals
   - Cyclophosphamide
   - Muscle-paralyzing drugs (e.g., curare)
3. Coercive Methods:
   - Forced seeing or hearing others being tortured (friends, relatives, spouse, children)
   - False accusations
   - Occasional indulgences
4. Somatic Methods:
   - Forced standing: prolonged standing in a required position, usually undressed.
   - Cold water: irrigation or submersion in cold water
   - Beating: with iron rods, rubber truncheons, whips, batons, sticks, etc.
   - Starvation: deprivation of water or food
   - Mutilation: dismembering of various parts of the body
   - Breaking bones
   - Sexual molestation: stripping, touching, attempted rape
   - Rape: homosexual or heterosexual
   - Electricity: electric shocks applied specially to eyes, teeth, head, genitals, rectum; "electric bed"
   - Fire: e.g., welding torches applied to head, eyes, genitals, etc.
5. Psychological Methods[b]
   - Denigration with insults, false accusations, use of brutal and threatening language, threats of execution
   - Sham execution
   - Execution of family members or friends in front of the victim
   - Video or audiotapes of the torture of other victims. including torutre of relatives, spouse and children
   - Witnessing homosexual or heterosexual rape performed on friends, relatives, etc.

a See references 1, 3, 5, 6, 7, 49.

b The separation of psychological from somatic is ony made for clarity sake. Any form of torture encompasses both psychological and somatic effects.

Although not all researchers agree [4], some studies have found that the psychological effects of torture are sufficiently characteristic to constitute a 'torture syndrome' [28, 29]. However, we still know little about what occurs to the human body and mind as the result of torture, notwithstanding the psychic and somatic changes observed. In general, the investigations of long-term psychological effects of torture are rare. However, a recent Danish study [4] sponsored by Amnesty International in which 135 victims of torture were examined medically and psychiatrically gives us an idea. The study showed that at the time of the examination, conducted between six months and a year after torture had taken place, 90 per cent of the victims complained of various symptoms which arose in conjunction with or following torture. Of those, 75 per cent presented psychiatric symptoms which included impaired memory, impaired concentration, mental changes and sleep and sexual disturbances. All the subjects had been healthy prior to their arrest. On the other hand, Allodi and Cowgil [28] investigated 41 cases of torture among the thousands of refugees from especially one Latin American country, who had migrated to Canada. The victims studied were 32 males and nine females, whose ages ranged from less than ten to 46 years of age (mean age 26.9). Twenty-five per cent of them had some university training; and except two females, they had experienced a total of 112 incarcerations ranging from weeks to a year (one victim had been imprisoned 11 times in five years). All were subjected to physical and psychological abuse. Allodi and Cowgill concluded that all suffered from a homogenous psychological disorder marked by severe anxiety, insomnia with nightmares about persecution, violence or their own torture experience, somatic symptoms, phobias, suspiciousness and fearfulness. In the case analysis they found that there seemed to exist a positive relationship between the individual ideological preparation, commitment and group support and psychological recovery from torture.

The sequelae at times could lead also to lesions in organs of functions not directly subjected to torture. For instance, Lunde, Rasmussow and collaborators (30) studied the sexual function of 17 men exposed to torture. They found that independently of cranial or genital trauma or severity of torture, 19 per cent of the studied victims presented sexual dysfunctions manifested as decrease in libido and/or erectile dysfunctions, in absence of abnormal pituitary or gondal hormones. In another study, Jensén Genefke and collaborators reported cortical or central cerebral atrophy, as determined by computerised axial tomography, in five non-alcoholic, previously healthy men ages 24 to 39 [31]. These men had been exposed to severe and prolonged tortures (mean of four years), and all had symptoms consisting of inability to concentrate, headaches, anxiety, depression, asthenia, sleep disturbances, cerebral asthenopia and sexual dysfunctions for several yars. A suggested possible mechanism, assuming that the atrophic changes cannot be attributed to head trauma, has been the possibility of high levels of cortisol secondary to the chronic severe stress of torture[32].

> We did not dare to kill them all (the political prisoners) when we could have done so and one day we shall have to release them. We must take advantage of the available time in order to make them go mad.
>
> Major Arguimides Maciel
> Director of Libertad Prison
> Uruguay

When confronting human behaviour, especially if it is deemed highly negative in quality, psychiatrists and field-related professionals tend to seek the roots of such behaviours primarily in the individual, or, at best, in his/her immediate surroundings. In such a narrow view, the torturer's behaviour could be easily conceptualised as one of a sadistic sociopath, brought about by defective parental discipline resentment over emotional deprivation, or more reductionistic, by congenital deficits or neurochemical imbalances in the brain. The problem with this intrasystemic orientation is that it selectively assigns causality intensively to one or a few individual elements, while disregarding or simply enumerating socio-economic conditions as aggregate factors in a multidetermined causality. The socio-economic system and the culture that derives from it is a basic element that shapes (and is shaped by) history, that dictates priorities and modifies environments.

Table 2: Specific Methods

'Submarine or 'Underwater treatment'	The victim is forced to submerge the head in a sink or bucket full of excrement, urine and water.
'The Hood:'	The victim's head is forced into a plastic bag, usually containing insecticide, until suffocation.
'Telephone:'.	Beating from behind simultaneously on both ears.
'Parrot Perch' or 'Pau de Arrara'	The victim's wrists and ankles are tied together and the whole body is suspended from an iron bar under the knees, leaving the naked body doubled over and defenseless. In this position electro-shocks are applied and filthy water forced into the mouth.
'Dogs Pit:'	The victim is kept a few feet above the ground as (s)he is hanged from the hands which are kept tied together on the back.
'Hook' or 'Hanging:'	The victim is hanged from a rope which is hooked to a strap around the waist, while the hands are tied to the back.
'Mitrione's vest:'[a]	The garment is gradually inflated until it crushes the victim's ribs and makes breathing impossible.
'Picada:'	A straight pin inserted most commonly under the victim's fingernails.

a Named after Dan Mitrione, a North American AID official, allegedly an advisor to the Urguayan police in counter insurgency techniques, including methods of torture [3, 9].

By focusing on the individual or his/her immediate family as the source of aggression, this theory avoids a critical examination of the problem. It ignores the history of societies which value highly certain types of aggressive behaviours, which glorifies the aggressive war hero, and which pretend that amassing destructive power is a deterrence of war and a preserver of peace. In other words, for the study of the individual that concerns us here we must look beyond the individual and his/her family, into the conditions that typically prevail in society which favours—and benefits—from such practices. The political torturer works in the name of the society, the army, the interest of the nation, etc. He is not the isolated maleficarum that our conscience would like us to believe; he is a member of an organised group that operates semi-autonomously, but does so under the direction of branches of the government—an element of a network devised to preserve power and facilitate domination. Does this mean that anyone could become a torturer? The answer is not black or white. Perhaps a now classical experiment better illustrates the dilemma. Some years ago S. Milgram conducted an experiment, 'Behavioral Study of Obedien cy' in a laboratory at Yale University [33]. The experiment consisted of 40 volunteers who were led to believe that they were to take part in an experimental design on memory and learning. Each volunteer was instructed to administer electric shocks to a learner-victim whenever (s)he gave an incorrect answer to a question. Although the victims never actually received an electric discharge, they had been instructed to pretend as if the shock had been experienced. The experiment was designed so that when the punitive shock had reached certain voltage, the teacher-volunteer had the option of stopping the procedure, but was verbally encouraged, and even firmly ordered to proceed administering shocks at higher voltage if the learner-victim failed to complete the task. In the experiment none of the 40 subjects stopped prior to shock level 300, at which the victim began kicking the wall and no longer provided answers to the multiple choice questions. At the end of the experiment 26 of the 40 subjects completed the series by administering 520 volts.

This experiment tells us about human potentialities, and how given the manipulation of certain variables, one can end up doing something contrary to one's expectations. Certainly, there are many aspects of the experiment that one can question, eg., who were the real victims here. But besides that, let us not forget that this experiment was conducted in one of the most prestigious universities in the United States, in the name of science, and in a contemporary industrial society where science is highly regarded. Therefore, the setting was one in which the average person would have difficulty believing that such an experiment could be wrong [34]. Many of the participants continued to shock the victims under much stress and pain, fighting the contradictoms and trying to justify the scientists' recommendations.

The point of this experiment is that ascribing to the individual torturer a particular psychopathology reveals nothing, unless there is interest in maintaining that if there were no sadistic-sociopaths, or that if they all received some sort of psychotherapy, this type of practice would stop.

How does the torturer become a professional in torturing? First, the external and material circumstances of his background must be such that will accommodate his nefarious occupation with relative ease. Second, he must be educated to be efficient and perform his work with determination. This eduction, given in schools of torture [1,35], sometimes with "instructors" from other countries [3, 35], aims not only at providing the torturer with the techniques for torment, but also at preparing him psychologically and ideologically for his labour. How is this mental preparation achieved? First, it is done by emphasising the non-humanness of target groups. The victim needs to be perceived as a thing, as something contrary to what the state, and the social class it serves, regards as the communal good—by educating this way the propitious condet is motivated and targeted. Secondly, training is done by conditioning the prospective torturers that they are to act for the good of the nation, the good of the country. Therefore, even the most brutal actions do not constitute a violation of the high moral principles under which they allegedly operate. Third, by education that emphasises loyalty to an organisation that will protect the individuals involved and maintain secrecy. This services to exculpate residues of personal responsibility while subordinating individual will to that of the organisation. Fourth, instructors simulate an aura of mysticism aimed at encouraging a long-term commitment and group cohesiveness. Torturers are frequently called by pseudonyms that stress certain personal characteristics, and some are even referred to as doctors [1, 36].

Despite these training and accommodating personality traits, it is likely that the torturer experiences some mental stress by tormenting his victims, and realizes that he is also the object of exploitation. He is usually a low-ranking employee likely belonging to a social class exploited by those whose interests he serves, and the mean for ends that are not truly his. This situation not only places him in severe contradiction that resonate in his practice, but also demands attempts at resolution on the personal level.

According to Festinger [37, 38], if an individual holds two ideas of mental sets that are not psychologically consistent with each other, he will experience discomfort produced by such inconsistency (or dissonance). In order to resolve the conflict the individual will either change both ideas or add a third one that will bring about less incon-

sistency. In other words, he will have to come up with something that will convince him that one of the ideas or sets is worth pursuing, especially if the ideas have already been transformed into acts. What is characteristic here is that the arousal of dissonance always contains personal involvement, and, in order to reduce the dissonance created, self-justification is the rule.

If we extrapolate this to the situation facing the torturer, then we can see that he finds himself in a dilemma: he needs to rationalise, to deny, to protect himself from the perception of his own doing. He needs to obtain some (subjective) gains, or else, due to the nature of his practice, he runs the serious risk of being flooded with unbearable stress that would break into his psyche and probably make him collapse (testimonies of victims of torture and agencies for human rights indicate that frequently the torturers torment their victims in a state of alcohol intoxication or under the effects of drugs [39]). The literature reviewed does not contain interviews or direct 'studies' on the psychology of the torturer, but by the nature of his practice and the accounts given by some torture victims one can infer some of the major psychological response mechanisms assisting the torturer. First, the torturer, not blind to the perceptions of his own doing, needs to distort reality, to exculpate himself from what and how he does, and to come up with maneuvers that would obscure the relationship between his actions and the effect they cause. Here the basic mechanism is projection: the victim is held responsible for his/her own suffering, a "you're getting what you looked for." But that transfer of blame is probably not sufficient, for the torturer knows he himself is the victimiser. Something more is needed: the torturer needs to dissociate himself from the victim, create distance, and he does it by ascribing a derogatory status to the victim (something he has been taught to do) which is, in a deeper level, a projected hatred of his practice and of his ultimate sponsors, and that *that* he will destroy in the victim. The contention here is not that the torturer is *the* victim, but rather that the problem is, we may say, dialectical. The torturer is the victimiser, but he has within himself the victim which he denies. That is, he conjures out his condition of (also) victim, by projecting it onto the tortured, and proceeds to destroy it. Thus, by torturing his victim, the torturer obtians three victories: one that comes from the triumph of having projectively annihilated his own feelings of victimisation by torturing others. Another victory is from avenging in the victim, his own displaced hatred toward those for whom he works and who are the real beneficiaries of his necrofiliac activity. But also, at another level, by torturing the victim, the torturer obtains a triumph over his own fear of retaliation and death, by being in absolute control over the lives of others.

Conclusions

To know and not to act is as if not knowing at all.
Old Japanese Proverb

Torture, as a structured apparatus used by nations to structure and maintain a given order of power relations, constitutes part of the daily experience suffered by thousands throughout the world. The case of several Latin American countries, whose governments not only declare themselves democratic, but which are also referred to as democracies by other governments, is a crude and typical example.

Here, I have described some aspects of that particular kind of torture, its known short-term and long-term effects, and its purposes, and elaborated on some psychodynamic elements under which the man who carries on with torturing probably operates. Of course, these elaborations do not pretend to be exhaustive, nor are they intended to be an apology for the men who actually do the torturing. Rather, the point is that these men should be understood in the historical and social context in which they operate, without forgetting who pays, who supports and who benefits from their practice. Fortunately, there exists throughout the world agencies and organisations concerned and vigilant of human rights which have bravely denounced torture, but unfortunately, those who are in the position of strength to exert necessary effective pressure over nations which indulge in such practice give lip-service criticism, or plainly ignore it.

Finally, I want to briefly mention another type of state torture that should concern us, but which due to its nature and implications will require a separate study. I am referring to the systematic, well-orchestrated and 'dosed' psychological and physical violence that a country, by virtue of its economic and military might, exerts over smaller nations and their people. Such smaller nations, due to their own historical and concrete existing conditions, lack the effective means to prevent such violence, or to respond with a likewise effective (defensive) counterforce.

[I want to express my appreciation to Dr. Kathy Blee for reviewing this manuscript and helping to make it more legible. My appreciation also to Virginia L Gift who patiently typed and retyped the manuscript.]

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Participation of Doctors in Torture

Report from Pakistan

mahboob mehdi

Under the dictatorship of the late Zia ul Haq, the state legalised and actively used torture as a form of punishment in Pakistan. Invoking Islam and its so-called laws, the medieval practices of flogging, amputation, stoning and so on were put to widespread use. Although the government has changed, these laws have not been repealed, nor have those who practised them, including the medical profession who colluded in these acts been punished. This paper was circulated at the at the AI's conference on 'Medicine at Risk'.

TORTURE has never been taken seriously in the official medical circles of Pakistan. The teaching of health professionals in various institutions of Pakistan does not bring into consideration the question of torture and how health professionals should react to it. The code of medical ethics of the Pakistan Medical and Dental Council does not mention any thing about torture. Doctors who take part in torture do not face any disciplinary action by the Pakistan Medical and Dental Council. In Pakistan the participation of doctors in the process of torture is usually legal and has been made part of the duties of the doctors.

The following types of the medical participation in the process of torture is seen in Pakistan.

(1) Under the execution of the punishment of the whipping ordinance of 1979—before the execution of the punishment commences, the convict shall be medically examined by the authorised medical officer so as to ensure that the execution of punishment will not cause the death of the convict. If the convict is ill the execution of the punishment shall be postponed until the convict is certified by the authorised medical officer to be physically fit to undergo the punishment. The punishment shall be executed in the presence of the authorised medical officer at such public places as the Provincial Government may appoint for the purpose. If after the punishment has commenced the authorised medical officer is of the opinion that there is apprehension of the death of the convict, the execution of the punishment shall be postponed until the authorised medical officer certifies him physically fit to undergo the remainder of the punishment.

(2) In many interrogation centres, the person to be interrogated is examined by the doctor and declared fit for interrogation.

(3) The conduct of the prison medical officer in most of the cases is very unethical and falls very short of the United Nation's declarations and codes of conduct. Instead of providing the standard and best available treatment to the prisoners, the prison medical officers usually behave as part of the prison administration and take part in torture.

(4) Cover-up activities by some doctors such as providing false death certificates or false clinical records of the victims of torture is very common.

(5) If the court orders amputation of a hand or a foot as punishment then according to the law it will be carried out only by an authorised medical officer personally.

(6) I have interviewed men and women who were tortured in different torture chambers and prisons of Pakistan. These victims have given evidences about the participation of doctors in the process of torture. One of the victims interviewed is a doctors and he faced his own class fellow-doctor in the torture chamber.

Usally the doctors:

(a) Advice the tortures about the actual condition of the victim's health.

(b) Revive the victims sufficiently to undergo further torture.

For the first time in the history of Pakistan, we in the Voice Against Torture (VAT) have systematically raised the question of medical ethics in relation to torture. In a three-day seminar held in Islamabad one full session was devoted to medical ethics in relation to torture, corporal punishment and other forms of cruel, inhuman or degrading punishments. We appealed to the Pakistan Medical and Dental Council to incorporate in its ethical code a clause against torture in line with the Declaration of Tokyo. In this session we declared that nobody in the world is medically fit for flogging. So doctors must not declare anyone fit for flogging. After the intervention of VAT in the medical scene of Pakistan more and more doctors have responded to the problem of torture. Thus recently at the 7th International Psychiatric Conference held in Karachi, different aspects of torture were discussed in a seminar attended by a good number of doctors. VAT fully coorperates in all such activities with its experience and documentary resources.

Torture was always endemic in Pakistan but during the last decade it reached epidemic proportions. Authorities often try to legitimise many crimes of torture by taking cover under religion. Due to this reason we are using the Declaration of Kuwait along with the Declaration of Tokyo. The Declaration of Kuwait is a good document relevant to the Muslim societies. It says:

> The medical profession shall not permit its technical, scientific or other resources to be utilised in any sort of harm or destruction or infliction upon man of physical, psychological, moral or other damage... regardless of all political or military considerations.

Voice Against Torture has been organised to achieve the following aims in Pakistan:

(1) To disseminate information among the people about the methods and purposes of all forms of torture prevalent here.

(2) To mobilise public opinion for the eradication of all forms of torture.

(3) To make the doctors realise that torture is a serious challenge to the medical profession.

(4) To make efforts that knowledge of torture and knowledge of the methods of treatment of people who have been tortured is incorporated in the teaching courses of doctors, physiotherapists, nurses, psychologists and social workers.

(5) To mobilise the opinion of the doctors in favour of the 1975 World Medical Association's Declaration of Tokyo.

(6) To make representation to Pakistan Medical and Dental Council to put the clauses against torture in it's code of medical ethics.

(7) To ensure that doctors do not participate in any procedure of torture. i e,

(a) They do not take part in cover-up activities such as providing false death certificates or false clinical records of victims of torture.

(b) They do not monitor torture by remaining present during any act of torture or by declaring any person fit for torture or by advising how far the tortures may proceed or by reviving victims sufficiently to undergo another bout of torture.

(c) They should not use their professional skill to extract information, control the prisoner or simply on punishment.

(d) They should strive to provide the best quality treatment to prisoners and people in detention; and should not have a biased attitude with them.

(8) To give all the support to the doctors who refuse to participate in the acts of torture, so that they and their families are not victimised by the different agencies of the state.

(9) To collect evidences against the doctors who have choosen to become instruments in the procedure of torture. To present these cases to the Pakistan Medical and Dental Council for necessary action; and to take these cases to the court so that the doctors may be tried for their criminal acts; and to expose them widely in the public and media.

(10) To mobilise opinion among the community of scientists in such a way that they should refuse to make instruments which could be used in the process of inflicting torture.

(11) To do research on all forms of torture, their effects and methods of treatment including rehabilitation.

(12) To provide free medical facilities for the treatment of victims of torture.

(13) To provide necessary specialised professional information to doctors who are treating victims of torture.

(14) To establish a specialised centre where victims of torture of any type could be referred from anywhere for treatment and rehabilitation.

(15) To keep cordial relationship with other anti-groups in the world. To exchange experiences with them and to participate in joint activities and seminars etc., with them.

(16) To cooperate with other human rights organisations nationally and internationally. To join hands with them for the struggle to eradicate torture throughout the world.

One important point to consider is that it is torture which has produced the struggle against torture. Geographically torture is not limited to few places. Irrespective of faith and ideology torturers are united internationally. They cooperate with one another. They exchange experience and technology. They do not like the struggle against torture. Those struggling against torture are in danger of becoming their victims themselves. It is, therefore, very important that those struggling against torture must also unite internationally irrespective of faith and learn from one another. They should exchange experiences and technology of the struggle against torture. They should plan measures for the protection of persons involved in anti-torture work in high risk areas.

Those involved in the struggle against torture and engaged in the task of treatment and rehabilitation of torture victims in high risk areas like Pakistan and many other third world countries need protection to ensure smooth, efficient and safe functioning. The following steps may serve this purpose:

(1) Recognition by the U.N. and relevant affiliated organisations.

(2) Support by Amnesty International.

(3) Support by different anti-torture organisations of the world.

(4) Support by different human rights organisations of the world.

(5) Participation in international seminars etc.

(6) Wide coverage in the international media.

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Doctor and Prisoner

Indian Prison Manual

colin gonsalves

THE Prison Manual contains several provisions relating to the health and well being of the prisoner. The duties of the Medical Officer are set out in Chapter IV. He has to keep a check on the medicine and the water supply. He shall oversee general sanitation. He shall examine and treat prisoners.

Under the provisions of Chapter XXXVI, when a prisoner dies, a report is to be made and submitted and the doctor plays an important role in this. If the prisoner is seriously ill and dies the relatives must be informed. If the death of the prisoner is "under circumstances raising a reasonable suspicion that some other person had committed an offence" this has to be reported to court in order that an inquest be held. Notices of death must also be sent to the municipal officer of health.

Immediately on the death of the prisoner the medical officer must be informed. The body must be left in the position found until the doctor examines the body. The medical officer is to prepare a report relating to the background of the prisoner and the circumstances of his death. This report along with the history of each prisoner is preserved for two years. Chapter XLV is titled 'Lunatics'. Normally most sick persons are to be sent to mental asylums. The provision most often relied on however, is the one which permits the government to keep the prisoner in a jail if no mental hospital is available for treatment of the prisoner. The exception to the rule has become the rule itself. Records are required to be maintained of the condition of the patient and the treatment given for a period of two years.

Criminal Procedure Code

Section 53 of the Code is as follows:

> 'When a person is arrested on a charge of committing an offence... that there are reasonable grounds for believing that an examination of his person will afford evidence as to the commission of an offence, it shall be lawful for a registered medical practitioner, acting at the request of the police....and *for any other person acting in good faith in his aid* (emphasis added)..., to make such an examination of the person...

Often this section is misused by the police. After torture the accused is sent to a doctor specially known to the police and co-operating with them for a medical report that the person was fit or for a report that injuries were found but they were inflicted by fellow prisoners.

Section 54 of the Code provides for medical examination of the arrested person at the request of the accused.

> When a person who is arrested alleges... at the time when he is produced before a magistrate or at any time during the period of his detention in custody, that the examination of his body will afford evidence... which will establish the commission by any person of an offence against his body, the magistrate shall, if requested by the arrest person... direct the examination of the body... by a registered medical practitioner...

Section 174 relates to the mode of inquiry to be conducted by the police in the case of deaths.

> When the officer-in-charge of the police station... receives information that a person has committed suicide, or has been killed by another.... or by accident, or has died under circumstances raising a reasonable suspicion that some other persons has committed an offence... he shall make an investigation, and draw up a report of the apparent cause of death, describing such wounds, fractures, bruises and other marks of injury as may be found on the body....

Note that the medical officer is not involved at any stage in this investigation. A complete medical examination is expected to be done by a lay person.

In the case of the death of a woman however, the section provides for an examination by the "nearest civil surgeon *or other qualified medical men appointed in this behalf by the state government* (emphasis)".

It would be interesting to study the background and performance of the doctors appointed by the government. In many cases it appears that these persons appointed must 'qualify' in that, they must be willing write reports and conduct examinations according to the bidding of the police. The need for an independent body of doctors free from the intrusive forays of government is most necessary.

Some Cases

Veena Sethi's Case (AIR, 1983, SC. 339) drew the attention of the Supreme Court to the atrocious conditions of the prisoners in the Hazaribaug Central Jail rendering them insane. The prisoners were detained in jail for very long periods of time though they were declared insane because "there were no adequate institutions for treatment of the mentally sick". The judge's were told that there was only one institution in the state of Bihar, for the treatment of the mentally sick and that was the Mansik Arogyashala but that was overcrowded. The judges said "we have had occasion to see lunatic asylums in one or two states and we find that the conditions in these is wholly revolting and one wonders whether they are placed for making insane persons sane or sane persons insane".

The court then took up the case of Gomia-Ho. He was convicted in 1945 and sentenced to three years in prison. In 1948 he was found to be of unsound mind and directed to be kept in the Hazaribaug Central Jail since there was no place in the mental hospital. Half yearly reports regarding his mental conditions were required to be submitted

(Cont. on page 72)

Press Reports on Human Rights Violations in India

A Tiny Sample Study

ALERT citizen's groups in many places over the world have contributed much to exposing human rights abuses by state organs and to biases in reporting through forming 'media watch' groups. The idea is to carefully scan media reports and, (as somewhat we have done here) classify the data collected. Such scanning also clearly highlights policy biases in reportage by government-controlled or other partisan media.

In order to make a small random study of press-reports on human rights violations, we turned to two files maintained by the Centre for Education and Documentation Bombay, one on police atrocities/encounters/combing operations/brutality and the other on 'civil liberties/democratic rights/infringements/organisations/enquiries etc'. There were no direct reports on specific instances of violation in the second category for the period we looked up: July-September 1988. The first file yielded 32 items from nine major dailies and five magazines. We did an exercise on classifying these reports in two ways i)statewise and ii)by type of human rights violation—an arbitrary but marginally useful exercise.

What we drew from our classification is as follows: 8 reports from Maharashtra (2 from Bombay but most others also from areas nearby), 3 from Orissa, 2 from Bihar and UP and 1 each from Delhi, Gujarat, Karnataka, Nagaland, Punjab, Rajasthan and West Bengal. (4 items were 'repeat' reports not counted here and 3 not clear). Three reports covered the whole country. (Of course, it must be pointed out that at CED we receive more dailies from Bombay than anywhere else. Hence perhaps the large number of instances reported for Maharashtra).

The 'type of human right violation' exercise yielded the following results:

1. Torture/death in lockup	6
2. Police beatings/assault	5
3. Illegal arrests/detention/seizure	4
4. Marauding, terrorisation, oppression of depressed sections	3
5. Direct killing/shooting	2
6. False encounters	3
7. Sexual abuse (including gangrape)	3
8. Framing false charges	2
9. General reports on human rights abuse on state/nation basis.	5

(one report has been counted under both 3 and 7).

Scanning these reports, there seem to be two major categories of 'motives' for these acts. In half the cases, the victims have clearly been earmarked for political repression through the use of violence (and abuse of machinery that is supposedly meant to protect the rights of common citizens). Roughly another half are simply victims of the police machinery blatantly overstepping its brief: either out on a drunken, marauding spree or unleashing calculated brutality against weak, marginalised sections and/or person(s) who have in some way (sometimes unwittingly) exposed the weaknesses in the state machinery.

R R

(Cont. from page 64)

but were not. He was, however, examined in 1966 and found to be sane. Yet he rotted in jail. In 1981 after news of his detention was published in a newspaper he was once again mentally examined and found to be sane. He was released in 1983 almost 35 years too late.

Like Gomia-Ho there were cases of many other prisoners who were kept in jail as the mental hospitals were full.

In *Charles Sobhraj's* case (1978, 4.SCC.494) the prisoner was kept day and night under bar fetters. The doctor examining the prisoner had noted:

> 09.2.1977: Multiple infected wounds on right ankles. Bar fetters be removed from right leg for 15 days (Sd) Dr. Mittal R.M.O.
>
> 12.2.1977: Bar fetters also to be removed from left foot. (Sd) Dr Bokra.

The supreme court severely restricted the use of bar fetters and condemned their generalised and indiscriminate use. Case of torture in police lock-ups and prisons are routine and endemic. The role of doctors in this is dubious. They are mainly used for cover up purposes.

Appeal to Subscribers/Readers

We regret that the last few issues of the *Radical Journal of Health* have been delayed. This has been because of printing and other difficulties, none of which fortunately are insurmountable. We hope to bring the publication up-to-date in the next couple of months. Please bear with us!

The RJH is for you and is sustained mainly by the support of regular readers like you. So far the journal is being subsidised by donations from concerned individuals. We would not like to pass on the burden of the extra cost to our readers by increasing the subscription rates. The Socialist Health Review Trust, the publisher of RJH has started a campaign for creating a corpus fund which can continue to absorb the extra cost as far as possible.

We appeal to you and your friends to generously contribute to this fund. *All donations may be made payable to the Socialist Health Review Trust and are exempted from Income Tax under Section 80G of the Income Tax Act.*

Implication of Physicians in Acts of Torture in Uruguay

gregorio martirena

In 1984, prompted by public protest against the widespread use of torture against political prisoners, a National Committee on Medical Ethics comprising doctors, medical students and lawyers was set up. Its findings have led to the drawing up of a Code of Procedures for trying the numerous complaints against the doctors participating in torture. (Reprinted from the Danish Medical Bulletin, *August 1987)*

FOR us physicians who have had the sad privilege of living for over a decade under totalitarian regimes that practise terror and torture and which, in turn, are supported by multinational expansionist economic interests, there is a pressing need to develop and refine international medical initiatives against torture. For those who govern by applying the National Security Doctrine, torture is a basic was fundamental element. In the words of my Chilean colleague, Dr. Serio Pesutic, there is no better way to defining torture than as *a dehumanised use of power.* Torture is implemented by those who are dominant, especially against those who threaten to undermine submission to their rule.

Torture has a Dante-esque etiology. It is the only man-made disease whose intention is here and now. In it, the first sick factor is neither the victim nor the torture, but rather the society which provides the opportunity and incentive to use torture. In all its degrees and expressions torture is nowadays deeply selective. Those who suffer it are those who are able to organise large crowds of people and who follow their own conscience. Torture tends to damage individuals without causing them to die, rather than obtaining information from them. This has led to the need for physicians to participate in implementing and sophisticating it. Among other things, means are sought to torture without leaving marks in order to make any denouncement lose legal validity, since such complaints are exclusively based on the testimony of the victims which is met with the cynical denials of those responsible in the security services.

Today, we are able to single out these points as the cornerstone of torture in the Third World. This, then, is the time when the figure of the military doctor assumes a central role as protagonist in his functions, his practice, and his aims.

Until the beginning of the early 1970s, the great majority of medical doctors who served the health units of the Uruguayan Armed Forces did so as civilians practising their profession. The Armed Forces Function Act (No. 14,157) along with Article 50 of Decree No. 783/73 ordained that the practice of their rights and the fulfilment of their professional duties be subordinated to military regulation. Likewise, their professional tasks were subordinated to the military authorities in direct opposition to the universal values of medical ethics.

The adoption of the National Security Doctrine meant an ideological purge of the armed forces, since anyone considered a danger to that ideology was dismissed from his post. Undoubtedly, this fact along with the abovementioned decrees make it absolutely valid to say that the military doctors were the medical part of the repressive apparatus which committed innimaginable gross violations of human rights. To many people, such affirmation may seem too simplistic; but here we are not talking about the ordinary man in the street or about those who had no other job opportunity than to enter a military garrison. We are talking rather about physicians trained culturally and scientifically at a free university. This is why we cannot understand that they have collaborated with those who directly oppressed our entire people.

The University of the Republic and the Uruguayan medical profession have been the primary pillars of our social gains for more than 40 years. For these institutions, every medical doctor owes respect and, above all, the doctor's respect is owed to a professional condition that identifies him or her with the health of others. Impositions from the established hierarchies can only alienate them from carrying out their professional duty, resulting in a serious disregard of medical ethics.

Consequently, a military doctor is not released from his ethical responsibilities if he enters service in the armed forces, since this only constitutes a minor addition to his fundamental condition of being human and being a physician—conditions from which he can never be returned. The implementation of an alienating training system with the imposition of a discipline aimed at estranging him from his humanity and his moral conscience as a doctor is impermissible. It is also incompatible with real medical training and with responsibility for the training of other doctors, because for these situations the greatest measure of freedom of conscience is required.

Although this is an affront to medical life in Uruguay, it is an historical fact that certain military doctors participated actively or passively in torture or violated ethical norms they ought to have abided by when carrying out orders from their superiors. In addition, we find a collective responsibility on the part of military doctors for neglecting to issue denouncements when such acts occurred—even today, a year and a half after democracy has been restored. This happens despite the fact that they belong to an institution which unquestionably has implemented measures that violated human rights on such

a wide scale and with so ample evidence that no one could ignore it.

In July 1984, the 7th National Medical Convention took place. On this occasion, public denouncements were reiterated of the systematic torture used against political prisoners as well as the violation of basic human rights on the part of the dictatorial government in Uruguay. Faced with these facts, a National Committee on Medical Ethics was set up. Its task was to study the denouncements and make decisions on them. Moreover, it was to prepare the elaborate a preliminary bill of compulsory medical association membership with its corresponding ethical code. These are long-standing aspirations of the Uruguayan medical profession that even today have not yet been achieved.

As a precedent, there is the decision made by the Uruguayan medical profession on October 27, 1984 to expel Dr. Eduardo Saiz Pedrini. Before that, an extraordinary tribunal set up by the Medical Federation of the Provinces found him guilty of violating the principles of medical ethics of the United Nations by giving perjured evidence in the certification of death and by covering up the torture suffered by Dr. Vladimir Roslik, who died on April 16, 1984, at Fray Bentos Military Garrison.

On March 4, 1985, the National Committee on Medical Ethics commenced functioning. It was made up of physicians representing the Uruguayan Medical Union and the Medical Federation of the Provinces along with the Association of Medical Students; in addition, it included members representing the Uruguayan Bar Association and its Human Rights Committee.

From the outset, and as the denouncements from released political prisoners began to pile up, those who had the honor to be designated members were faced with an incredible range of horrors. The constant factor in them all was that physicians played an active or passive part. There were the doctors who took down data on the prisoner's entrance record. This enabled those who were directly in charge of the torture procedures to know the person's physical or mental weakness or disability, enabling them to act with a maximum of ferocity on those points. There were the doctors who were unconcerned about giving direct care to sick prisoners, who delayed consultations, refused medication and specified diets, etc; the doctor who stepped in when the torture victim's life was at stake, thus succeeding in returning him to consciousness, only to send him back into the torture machine; the doctor who falsified the death cause of prisoners, performing incomplete autopsies or issuing death certificates many times without directly examining the bodies concerned; and the doctors who directly participated in torturing those interrogated or conducted a constant mental harassment of the prisoners, seeking ways to break down their personalities.

In this notes on *Reflexiones Para un Judicio Etico-Medico* (Reflections for an Ethical/Medical Judgment), Dr. Rodolfo Schurmann P., expert in criminal law and member of the National Committee on Medical Ethics, writes: "Many of these practices can be comprised within criminal offenses such as *injuries, abuse against detainees, private violence, covering up,* and *failure to offer medical care.* This does not mean that they are not reproachable from an ethical/professional viewpoint; on the contrary. Taking into account the seriousness of the malpractice, this goes beyond the strictly ethical field and falls into that of criminal law. Thus, two negative judgments can be passed which may coincide in the sentences, but where each is independent. It is true that, as a rule, all criminal acts involve an ethical depreciation, but not all ethical deprecation involves crime. The principle of legality underlying criminal law eliminates in this regard the elasticity or fluctuation of ethical norms *(nullum crimen sine lege)*."

In our country, there has been neither a regular organ specifically for 'trying' unethical conduct nor an applicable code. Thus, the new committee faced the need to study the existing principles for it to act upon:

A *Internationally Approved Principles*

Global:

—The Universal Declartion of Human Rights, 1948.
—The Declaration of Geneva, 1949.
—International Agreement on Civil and Political Rights, 1966.
—Declaration on the Protection of All Persons from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1975.

Regional:

—The Pan-American Convention on Human Rights, 1969.

B *National Regulations*

—Act No. 1088 of 1870 (concerning the Army: abolition of flogging and other punishments involving torture).
—Present constitutional precepts in force: Articles 26-72 and 332 of the Magna Charta of 1967.
—Act No. 15737 on Nonreciprocal Amnesty, issued on March 22, 1985.

C *Special Regulations and Codes of Ethics*

—The Declaration on Tokyo, adopted by the 29th World Medical Assembly, 1975.
—Principles of Medical Ethics, United Nations, 1982.

According to Dr. Schurmann, the fundamental guidelines—one could almost say the cornerstone—in the worldwide system of ethical responsibility in this field are those adopted by the United Nations General Assembly on December 18, 1982.

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty

to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2

It is gross contravention of medical ethics, as well as an offense under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute pariticipation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

This is a clear affirmation of the concepts dealt with stating that *without exception of any kind* the supreme duty of all medical doctors is to prevent and cure disease for the patients who are entrusted to their care and to help them avoid suffering. The specific duty of military or police doctors is to offer the imprisoned persons the same health protection and the same treatment as they would give to nondetainess. Correlatively speaking, their highest duty is not to inflict on the people who are deprived of their liberty any sort of cruel, inhuman, or degrading treatment. By virtue of the profession they exercise, physicians hold unimpeachable duties vis-a-vis mankind which extend beyond considerations of interest in the personal, economic, admnistrative, political, or 'national security' spheres.

Furthermore, it became necessary for the committee to draw up a Code of Procedures for dealing with and trying the numerous denouncements it received. In this manner, the accused physicians will enjoy the widest possible guarantees for their defense and discretion about the alleged offeness.

In each case, at the committee's plenary session, an inquiry team is set up consisting of a physician and professional aspects while the lawyer ensures that the correct procedure is abided by. After studying the case in depth, including a justification from the alleged offender, who has a right to legal advice and may call witnesses, the team writes its final report. Subsequently, this is submitted to the full committee for approval, amendment or rejection. If it is approved, the accused doctor is informed. He is then offered a chance to present an apology; if this is accepted by the full committee, a new trial is stipulated. Should the concerned doctor not wish to respond, the ruling is put on record.

After the ruling is official, the next step is up to the medical doctor's professional associations (*Sindicato Medico del Uruguay* and *Federacion Medica del Interior*). They decide on professional disciplinary sanctions according to the details of each case and bring relevant legal action when necessary.

The National Committee on Medical Ethics has now been functioning for a year and a half, and we can show the world only three verdicts on the participation of physicians in torture, despite the fact that we are looking into more than a hundred specific denouncements.

Today, a year and a half after the democratic government was installed—and despite the official mission of the Uruguayan government, which led the United Nations to lift its sanctions against the country for violations of human rights during the years of dictatorial government—we can show the world only a small total of publicly established violations of human rights despite the fact that the whole nation is convinced that such violations took place; a completely intact army with its intelligence and security systems still in force and constantly pressuring the government's political decisions; a state which has not yet determined whether a civilian or a military court is to be in charge of prosecuting those responsible for the misdeeds of the past; and only one bill of Regulations for the protection of Human Rights, namely No. 433 of December 1985, proposed by Senators *Alberto Zumaran and Hugo Batalla* on behalf of the political opposition parties and which has not yet been dealt with in any depth.

Facing the reality of *obstacles* imposed by the government, we as physicians feel proud of the few, but unbending penalties and denouncements made against those who violated the universal ethical principles while carrying out their functions as military doctors. *Now, once again we turn to the worldwide medical community for solidarity and to propose some joint course of action:*

—A set of rules adopted by medical organisations everywhere which shall be binding for physicians when exercising their profession, for their relationship with the society they live in and with the government they are attached to.

In her study on 'Deontology and Repression' Dr. Susana Eirin, a lawyer and member of the National Committee on Medical Ethics, says that in times of moral decay, when a society enters a crisis, all its members are affected by such "memoral shakeup." Before learning to become a physician, one has to learn to become a human being. It may not be possible to lay down exact guidelines for the behaviour of individuals in an environment that is becoming difficult; but it certainly is important for those who start practising a profession to be given norms of conduct in the face of the social crises which our societies in transition have to endure.

—It is necessary to define and implement universal teaching norms on human ethical and professional standards. In particular, the concept of due obedience, or obedience to superiors, should be defined as restrictively as necessary in order to avoid its use as a justification for any conduct violating human rights.

(Cont. on page 75)

October 27 1988, p 1) there is evidence of new cases of internment during the past two years.

Some psychologically healthy dissenters and human rights (HR) activists in the USSR are labelled mentally ill and subject to compulsory hospitalisation and 'treatment'. It is argued that the Soviet approach to psychiatric diagnosis, particularly the concept of schizophrenia, is a critical factor in labelling dissent as mental illness. Such activity is not simply conformance to the prevailing political system by one sympathetic part of the health bureaucracy. It would appear that psychiatric theory and practise have been systematically bent in the USSR for this purpose—a large-scale, cross-cultural WHO study showed that Soviet psychiatrists have a broader concept of schizophrenia and a unique system of categorisation that differs from that of other psychiatrists worldwide. The Sovieztinevsley school which dominates Soviet psychiatry is "... characterised by extremely broad diagnostic criteria, extreme schematism in classification and overwhelming pessimism in prognosis". It postulates that schizophrenia is genetic in origin, irreversible and deep-seated.

The forensic (legal) implications of the Soviet view are also far-reaching. It states that "schizophrenia is a disease in which patients are, with rare exceptions, deemed not responsible (for their behaviour)". Further, with the extremely broad conception of the disease, it is possible that the defendant, who is normal on examination, is still harbouring severe illness.

State-sanctioned torture can become a malignancy of the body-politic. The political system, professional group, public opinion and individual values—these establish norms of conduct, and normally these norms do not conflict. The fact that professionals face dilemmas when conflict occurs underscores the importance of developing ethical standards. An epidemiolocal approach, such as exists in the form of a national network in the US to study the social 'causation' and medico-social implications of murder, is suggested.

Since the people who stand to benefit from TPA are usually those in political positions to sustain it; preventive strategies must be aimed at those in power. Protection of human right is based on three methods: pressure by the international community; actions by national judicial system; and enforcement by international or regional bodies (such as the UNHCR).

Governments bear the 'shame of exposure'. Systematic collection of information by national groups is important. The International Committee of the Red Cross (ICRC) has probably the most detailed information worldwide; visiting prisoners worldwide to check on detention conditions as specified in the Geneva Convention. The International Medical Commission for Health in Human Rights (Geneva) could probably coordinate a data network on epidemiology, suggest the editors in their concluding chapter.

Research on how and why reasonably normal people get co-opted into perverse practises is also important. R.J. Lifton has suggested that one of the key concepts underlying Nazi medical killings was belief in the legitimacy of destroying 'life unworthy of life'. Lifton suggests that the Auschwitz doctors sometimes experienced ethical conflicts but were able to resolve them through a process of 'doubling'—creating an 'Auschwitz self' as well as a humance-husband father self—even as they killed, they held on to the idea that they were healers.

Medicine has become part of society's explicit political response to the general predicament of humans. Medicine is now an institutionalised social instrument employed for the general political purposes of the community—regulating birth and mortality rates, controlling epidemics, etc. In the circumstances, HPs have a positive duty to protect its ethical tenets. As the book states—we are now technically capable of treating bodies and minds effectively on a large scale. To put Orwell's fears of 1984 behind us, we must put medical ethics and internationally defined human right in front of us.

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(Cont. from page 67)

Concerning the erroneous demand of 'loyalty', in *Rafael Bielsa's* book *La funcion publica*, (Ed, Depalma, Buenos Aires, 1960, p. 34.) (Public duties) we read as follows: "The meaning of collaborating in public administration is not that of a partnership where everything must be accepted and legitimised. On the country, it implies checking, revision, objections, observations, and even well-founded opposition to any illegal or inappropriate act contrary to public interest." All professions should have a certain autonomy enabling them to resist pressures from the political systems in which they operate.

Finally, let us be united in our intentions and as physicians recall this statement from the Declaration of Geneva: "I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity."

Let this be poignantly rooted in our consitences so that society and all its institutions and organs can not accept the practice of torture in their midst ever to happen again. Likewise, let it no longer be allowed that physicians alienated from their medical standards act as unconscious robots for the military in prower. ***Let us under no circumstances whatsoever permit the existence of statutes, enclaves, or hierarchies that engender posibilities for such barbarity.***

Mission to Chile

Report of World Medical Association

andre wynen

Since 1984 the Chilean Medical Association has been actively campaigning against the use of torture and against the physicians who participate in it. In July 1986 during a general protest strike two office holders of the association were arrested and taken to prison. The association invited the secretary general of the World Medical Association to help free them. This is a report of that visit.

DR. J. L. ONZALEZ REUES and Dr. F. Rivas Larrain, president and secretary general of the Chilean Medical Association, were arrested on July 10, 1986 and taken to Capucinos, an annex of the public prison in Santiago. In the last three years, the Chilean Medical Association has been campaigning vigorously against the use of torture and against physicians who participate in it. I had been to Santiago, Chile, in February 1984 to hold a press conference in which I expressed the WMA's full support of the actions taken by the Chilean physicians.

Last year, the Chilean Medical Association joined other professional groups (lawyers, engineers, arthitects, etc.) to create a national civic assembly. Dr. Gonzalez was elected its president. The purpose is to unite all groups opposed to the regime. The Chilean Medical Association's main cause is to defend the rights of the patient and medical ethics, which is directly linked with the defense of human rights.

The National Civic Assembly called a two-day general protest strike (July 2-3), during which violent confrontations between civilians and military patrols led to three deaths and several injuries. Two young demonstrators were seriously burned, their bodie were found near the airport.

The version given by the opposition—based on testimony by witnesses, including that published by the Catholic Church—affirmed that an army patrol had poured gasoline over the victims. On the other hand, the government version stated reports by their witness that the accident had been caused by the victims themselves while handling Molotov cocktails. One of them died from the severe burns received.

Fourteen leaders of the National Civic Assembly—including Dr. González and Dr. Rivas—were detained on charges of inciting to riot and violence during the demonstrations.

Alerted by the Chilean Medical Association, the WMA secretary general issued a press release to international press agencies informing them about the situation and sent letters and telegrams to the Chilean government and the judiciary appealing on behalf of the two collegues detained. These measures were taken in concert with Amnesty International and the American Association for the Advancement of Science (AAS), among others. On July 24, the Chilean Medical Association telephoned and asked me to travel to Chile to help them in the effort to free their president and secretary general.

Contacts were made with the Belgian Minister of Foreign affairs and the Chilean ambassador in Brussels to discuss the feasility of an urgent mission to the Chilean government and the judiciary. Several meetings were arranged in Santiago with the help of the Belgian ambassador in that capital. In August, I arrived in Santiago to meet with the Belgian ambassador and with representatives of the Chilean Medical Association, thanks to Dr. Jorge Jimenez de la Jara who assisted and interpreted during my stay in Santiago.

On Sunday, August 3, the first visit to Drs. Gonzalez and Rivas took place and preparations were made for the forth-coming meetings with government authorities and the judiciary. My last day in Chile, August 6, a second visit with the imprisoned colleagues was allowed and prior to my departure for the airport, a press conference was held at the headquarters of the Chilean Medical Association.

I wish to stress that at all times I was received with deference and kindness by all those with whom I met. Perhaps this can be attributed to the fact that I was announced as the representative of more than two million free and independent doctors not connected with any communist country and to the excellent liaison work done by the Belgian Foreign Affairs department, the Belgian ambassador in Santiago, and the Chilean ambassador in Brussels.

In Chile I met with:

—Alberto Cardemil, under-secretary of Internal Affairs, known as the Government's key man in repression activities against the opposition;

—Hugo Rosende, Minister of Justice and personal friend of Dr. L Gonzalez;

—Dr. Winston Chinchon, Minister of Health, and his chief of staff, Dr. Ricardo Caram;

—Rafael Retamal, president of the Supreme Court;

—Judge German Valenzuela Erazo, President of the court in charge of the affair and responsible for the final ruling;

—Professor Amador Neghme, President of the Academy of Medicine;

—Monsignor Sergio Valech, Ausxiliary Bishop, leader of Catholic action in the country.

From these meetings, I gathered that the lawyers had

not petitioned for the prisoners to be released on bail. Therefore, during my meeting with Judge Valenzuela, I officially presented a request for the release of Drs. Gonzalez and Rivas, pledging the moral guarantee and support of the two million physicians represented in the WMA.

I was authorised to inform the Chilean government that in the event these two collegues were convicted, Belgium and I, myself—as well as the University of Louvain, represented by its Rector, Monsignor Massaux—were ready to grant them asylum if their sentence were commuted to exile, which the Chilean government would be willing to consider. If so, the Belgian government would permit them to practise in Belgium during their exile and under the same conditions as Belgian physicians.

Advised of this possibility, Drs. Gonzalez and Rivas were reluctant on account of their solidarity with the 15 other people arrested for the same reasons. Their lawyers, in the meantime, confirmed their intention of requesting, within the next 48 hours, that the prisoners be released on bail.

A meeting was also held with Dr. Alvaro Reyes and Dr. Ramon Rojas who had spent three months in the same prison as Dr. Gonzalez and Dr. Rivas for failing to report to the police a wounded man they had treated at the Chiloe clinic. They had been released on bail the week before. Two other colleagues, Ramiro Olivares and Juan Macaya, are still in prison on the same charges. They work for Vicaria de la Solidaridad, a Catholic Church human rights organistion in Santiago.

I had the opportunity of visiting las Condes private clinic and El Salvador University Hospital, where I was received by Professor Umberto Reyes, Head of the Internal Medicine Service. There is an indescribable contrast between the luxury of the clinic and the meagerness of the hospital, which is so deprived of the most essential equipment and personnel that it has been forced to close some of its departments for lack of resources.

The enormous discrimination between medical care available to the rich and to the poor raises a serious ethical problem and is unquestionably conducive to considerations of euthanasia motivated by a total lack of medical care for the poor.

All physicians encountered, from heads of departments to medical students and residents, unanimously denounced this situation which they consider an unacceptable breach of human rights. They expressed their moral discontent by actively supporting the opposition and by their solidarity with Dr. Gonzalez and Dr. Rivas and the National Civic Assembly they had helped to create and which they diligently direct.

As mentioned, the visit ended with a press conference during which an objective report was presented on what had been done in Santiago. Special emphasis was gives to the total independence and apolitical attitude with which the assignment had been accomplished. The support received in Belgium and the assistance given by Belgian diplomatic circles, the Chilean Medical Association, temporarily presided over by Dr. Acuna, the Chilean Academy of Medicine, the Universities, and the Catholic Church were duly acknowledged and appreciated. Recognition was given to the Chilean authorities and judiciary for their understanding. Obviously, they were impressed by the World Medical Association's moral prestige and the strength it represents. I said that I hoped Chilean justice would take into consideration the detainees' moral and professional values, which no one I met questioned at any time. In conclusion, I would like to note how impressed I was by the enormous contrast in Chile between, on the one hand, the serious government action against the basic principles of medical ethics and human rights—the latter now under review by a commission headed by the department of the interior and a group of jurists and lawyers—and, on the other hand, the great freedom enjoyed by a vigorous opposition press, the freedom of opponents to express themselves against the regime, and the absence of border control mesures.

No entry or exit visa was required, and luggage was not searched at any time. Neither was this an exception because of the special nature of my trip. The rules are identical for all travellers, and this was confirmed by colleagues in the Chilean Medical Association. Nobody was able to explain whether this contrast should be interpreted as a strength or weakness of the government.

On August 19, I was informed that Drs. J. L. Gonzalez and F. Rivas had been released on bail that day and authorised to stay in Chile. Drs. Ramiro Olivares and Juan Macaya were also released for days after my visit to Santiago. The Minister of Health, Dr. Chinchon, was dismissed from his functions in the government a few days after my visit.

Correction

In the June 1988 issue please note the following correction in Health Care, Health Policy and Underdevelopment in India by Ravi Duggal. On page 17 the sentence beginning 'The fact is that Britain's... should read: The fact is that Britain's and USA's state health expenditure was equivalent to India's national income and their health care facilities between 30 to 40 times more than India. This gap is even worse today. In 1984 health expenditure in the USA was $ 1,580 per capita per year out of which state expenditure accounted for 41 per cent.

On page 20, the sentence beginning 'The budget skyrocketed' should read. The budget skyrocketed from a mere Rs 2.2 crore to Rs 25 crore in the third plan.

The title of table 1 should read Growth of Health Infrastructure and Investment in India. The figures in brackets in column 2 refer to private hospitals and in column 5, rural beds.

Action Against Doctors Involved in Torture

francisco rivas larrain

In 1982 with the institution of free elections to the Colegio Medico de Chile which was charged with ethical supervision of the profession, there has been much reorganisation and a new code of ethics has been prepared and is implemented vigorously despite opposition from the political authorities.

TORTURE has been practised in Chile systematically and continuously since the coup of 1973. There is sufficient evidence that those responsible for torture in Chile are the security institutions of the armed forces, the police, and the government security agencies: first Direction de Inteligencia Nacional (DINA), followed by Central National de Informaciones (CNI) to the present time. Thousands of cases of torture perpetrated by the above institutions have been documented and denounced by Church and human rights organisations, professional colleges, and international institutions.

In Chile, the armed forces have always included physicians, civilians as well as those with military rank. Until 1973, however, military doctors were shown the same respect as other doctors and were not burdened with the suspicions which are now cast upon them.

During the dictatorship, over 80 physicians directly or indirectly participated in acts of all-treatment, humiliation, or torture; the great majority of these physicians belonged to the armed forces and were attached to the security agencies.

From 1973 to 1982, the officers of Colegio Medico de Chile were appointed by the military authorities. Servile and obedient, these officers heard reports of physicians participating in acts of torture but did nothing to investigate or denounce them.

In 1982, the government enacted a new law on professional colleges, whereby the organisation of more than one college was permitted and authority of the Colegio Medical de Chile for ethical supervision of its members was revoked. Simultaneously, the law allowed free elections to be held in the Coliegio. The pro-Pinochet, prodictatorship position was defeated at these elections, and the officers elected fully represented the opposition.

The Colegio's new authorities set themselves three major lines of action:

(1) Defense and protection of physicians against abuse from the Ministry of Health and optimisation of the Solidarity and Welfare of Departments of the Colegio Medico.

(2) Defence of Chilean public health. Criticism of and mobilisation against those health laws which the government seeks to impose which are arbitratry and elitist, beneficial to higher- income sectors. Report of poor conditions for medical service and near-irreparable deterioration of the Chilean hospital system, which until 1973 was a model of high quality and efficiency.

(3) Struggle to defend, protect, and encourage human, social, and political rights of physicians and all citizens of this country.

This last item has evoked the vigorous, undeviating will of the Colegio Medico to investigate the part played by doctors in all forms of violation of human rights, especially torture.

Since the democratic election of its officers, the General Council of the Colegio Medico has reorganised its Department of Medical Ethics and set up a Human Rights Committee.

From their inception, these departments began to receive reports of the participation of doctors in acts of torture. These reports have been divided into cases where evidence is obtainable and cases which, though undoubtedly true, lack conclusive proof for an investigation. All these reports have been received by the General Council of the Colegio Medico through the regional councils across the country, channelled by the Ethics Department and the Human Rights Committee.

To date, two cases involving four physicians have been investigated and tried; two of the doctors were suspended from the Colegio for one year, the other two were expelled. In addition a trial of another three doctors responsible for the death from torture inflicted by members of the security agencies in a northern city is reaching its final stage.

In the first two cases, the accused were found guilty of negligence in the medical examination of individuals under arrest who were subsequently tortured; various extenuating circumstances were taken into account. In the other two cases, most serious breaches of ethics including negligence in medical examination, wilful omission in reporting lesions, insufficient and unreported treatment of torture victims, issuing false health certificates, together with the absence of extenuating circumstances, deserved the sentence of expulsion from the Colegio Medico.

The above trials were conducted impartially and impeccably by the General Council of the Colegio Medico which is its highest court with renowned counsel acting for the defence of the accused. All counsel, including counsel for the defense of the doctors expelled from the college, agreed that the medical court had shown exemplary fairness and impartiality. Furthermore, not only have the Chilean public opinion and the international

medical community (World Medical Association) acknowledged the same merits, but also the entire body of Chilean physicians have recognised the fair-mindedness of the General Council in dealing out justice and in its generosity towards the culprits.

However, the efforts of the Colegio Medico in this area did not stop there. A new code of ethics was prepared and drafted. At the preliminary meeting held recently in Montevideo to restore the Federation of Medical Associations of Latin America, this code was taken as a model for a continental Code of Medical Ethics.

Our efforts are known beyond our frontiers; we have reported on them before, as we are doing today, with both pride and shame: With pride, because in the midst of cruel dictatorship we have been able to denounce and punish the henchmen of terror and death; with shame, because the men we have tried are physicians, Chilean physicians who have taken the Hippocratic oath and made a commitment to life, not death. Neither is our fight for human rights framed within the bounds of medical ethics. Since we know that we are citizens before being doctors and that human and political rights are best protected in a democracy, we are also involved in the political struggle against the regime.

We say this with pride. The Colegio Medico de Chile penalises physicians who practice torture and strives actively to put an end to Pinochet's dictatorship. We are members of the Asamblee de la Civilidad de Chile, which embodies the 22 most representative social organisations in the country (blue-collar workers, rural workers, slum-dwellers, professional men and women, students, women, university academics, ethnic minorities, and others), and we are part of the plan for progressive civil disobedience designed to put an end to dictatorship. We have been jailed for it, and this we also declare with pride.

In Chile, physicians who practise torture are promoted in the armed forces; we doctors who denounce torture within the military circle of dictatorship are thrown into the jails of Pinochet. Unamuno spoke of peoples with a tragic sense of life. Of men who share this tragic feeling—the feeling that leads a man or a people to folly in the pursuit of freedom. Such folly is ours. To try a torturer under a regime with torture as its policy is folly. To foster civil disobedience under a regime that believes in sterlie order and vertical authoritarianism is further folly. To be jailed under a dictatorship that tortures and murders unhindered is folly, too.

We love such folly. It is the folly of Bolivar, Carrera, Manuel Rodriquez, and Salvador Allende: The sublime, heroic folly that made our peoples free. The heritage that allows us to know we are free and to continue struggling for final liberation of our country. We Chilean physicians know that the solidarity of Danish physicians and physicians all over the world is behind us. That is one of the strongest support in our struggle. We will put an end to torture when we recover democracy. Our victory will be your victory too.

[This presentation was made at the International Meeting on Doctors, Ethics and Torture in Copenhagen by Professor Bent Sorensen on behalf of Dr. Francisco Rivas Larrain, who had been imprisoned by the authorities in Chile on unspecified charges.]

Press Reports on Human Rights Violations in India

A Tiny Sample Study

ALERT citizen's groups in many places over the world have contributed much to exposing human rights abuses by state organs and to biases in reporting through forming 'media watch' groups. The idea is to carefully scan media reports and, (as somewhat we have done here) classify the data collected. Such scanning also clearly highlights policy biases in reportage by government-controlled or other partisan media.

In order to make a small random study of press-reports on human rights violations, we turned to two files maintained by the Centre for Education and Documentation Bombay, one on police atrocities/encounters/combing operations/brutality and the other on 'civil liberties/democratic rights/infringements/organisations/enquiries etc'. There were no direct reports on specific instances of violation in the second category for the period we looked up: July-September 1988. The first file yielded 32 items from nine major dailies and five magazines. We did an exercise on classifying these reports in two ways i)statewise and ii)by type of human rights violation—an arbitrary but marginally useful exercise.

What we drew from our classification is as follows: 8 reports from Maharashtra (2 from Bombay but most others also from areas nearby), 3 from Orissa, 2 from Bihar and UP and 1 each from Delhi, Gujarat, Karnataka, Nagaland, Punjab, Rajasthan and West Bengal. (4 items were 'repeat' reports not counted here and 3 not clear). Three reports covered the whole country. (Of course, it must be pointed out that at CED we receive more dailies from Bombay than anywhere else. Hence perhaps the large number of instances reported for Maharashtra).

The 'type of human right violation' exercise yielded the following results:

1. Torture/death in lockup	6
2. Police beatings/assault	5
3. Illegal arrests/detention/seizure	4
4. Marauding, terrorisation, oppression of depressed sections	3
5. Direct killing/shooting	2
6. False encounters	3
7. Sexual abuse (including gangrape)	3
8. Framing false charges	2
9. General reports on human rights abuse on state/nation basis.	5

(one report has been counted under both 3 and 7).

Scanning these reports, there seem to be two major categories of 'motives' for these acts. In half the cases, the victims have clearly been earmarked for political repression through the use of violence (and abuse of machinery that is supposedly meant to protect the rights of common citizens). Roughly another half are simply victims of the police machinery blatantly overstepping its brief: either out on a drunken, marauding spree or unleashing calculated brutality against weak, marginalised sections and/or person(s) who have in some way (sometimes unwittingly) exposed the weaknesses in the state machinery.

R R

(Cont. from page 64)

but were not. He was, however, examined in 1966 and found to be sane. Yet he rotted in jail. In 1981 after news of his detention was published in a newspaper he was once again mentally examined and found to be sane. He was released in 1983 almost 35 years too late.

Like Gomia-Ho there were cases of many other prisoners who were kept in jail as the mental hospitals were full.

In *Charles Sobhraj's* case (1978, 4.SCC.494) the prisoner was kept day and night under bar fetters. The doctor examining the prisoner had noted:

> 09.2.1977: Multiple infected wounds on right ankles. Bar fetters be removed from right leg for 15 days (Sd) Dr. Mittal R.M.O.
>
> 12.2.1977: Bar fetters also to be removed from left foot. (Sd) Dr Bokra.

The supreme court severely restricted the use of bar fetters and condemned their generalised and indiscriminate use. Case of torture in police lock-ups and prisons are routine and endemic. The role of doctors in this is dubious. They are mainly used for cover up purposes.

Appeal to Subscribers/Readers

We regret that the last few issues of the *Radical Journal of Health* have been delayed. This has been because of printing and other difficulties, none of which fortunately are insurmountable. We hope to bring the publication up-to-date in the next couple of months. Please bear with us!

The RJH is for you and is sustained mainly by the support of regular readers like you. So far the journal is being subsidised by donations from concerned individuals. We would not like to pass on the burden of the extra cost to our readers by increasing the subscription rates. The Socialist Health Review Trust, the publisher of RJH has started a campaign for creating a corpus fund which can continue to absorb the extra cost as far as possible.

We appeal to you and your friends to generously contribute to this fund. *All donations may be made payable to the Socialist Health Review Trust and are exempted from Income Tax under Section 80G of the Income Tax Act.*

Torture, Psychiatric Abuse and Health Professionals

r raghav

The Breaking of Bodies and Minds: Torture, Psychiatric Abuse and the Health Professioanals Edited by Eric Stover and Elena Nightingale, The American Association for the Advancement of Science/WH Freeman and Co., New York, 19855; pp 320.

THE book is a result of a symposium sponsored by the Committee on Scientific Freedom and Responsibility (CSFR) of the American Association for Advancement of Science (AAAS) in January 1981 on the subject. Through case history and analysis, the contributors examine the role of health professionals, (HPs) in the use and prevention of torture and psychiatric abuse (TPA) "in the context of the political, social and ethical forces that guide their actions". It addresses itself to such questions as—how and why HPs participate in serious violations of human right; what are the conditions under which such violations occur; and what can organisations of HPs, scientists and others do to check the trend.

As the book notes, "violations of human rights have become so well-organised, so systematic, so efficient, that it is now a kind of industry". Through careful documentation of abuse and lucid insights into the dilemmas of HPs and others working under repressive governments the book presents a clear delineation of the ethical issues involved. In the final chapter, the editors suggest organised monitoring, protest and action through professional associations to counter state-sanctioned routinisation of TPA for political purposes. To quote from the foreward, "It is now more urgent than ever that we use the extraordinary human capacity for learning, communications, and attachment to one another to foster the bonds of mutual respect".

Apart from sporadic misuse of authority or isolated abuses resulting from poor practice/lack of proper resources, TPA as a systematic means of political control are prevalent in at least 66 (nearly one-third) of the world's nations, notes the book. In this, HPs are collaborators in misuse of medicine, mis-certification of victims and other forms of flagrant and deliberate abuse of professional ethics. Alarmingly, "These collaborators in abuse are not simply mad doctors... satisfying their own sadistic desires; they include apparently normal HPs".

Extent definitions of torture are reviewed and their common features noted. In essence, torture is the deliberate infliction of pain by one person on another to break down the will of the victim. The degree of abuse that constitutes 'torture' sometimes needs clarification—for example, solitary confinement, in itself, is not torture under international law. TPA may include physical, psychological and pharmacological and psychiatric abuse forms. However, all torture invariably produces psychological distress in the victim.

Some Testimonies

"I realised that pain can always increase without end. To have that feeling is devasting for the mind. Absolute loneliness and endless time are abstract ideas... but when experiencing them, the desperation is hard to describe".

"The entire affective world... collapses with a kick in the father's genitals, a smack on the mother's face, an obscene insult of the sister, or the sexual violation of a daughter. Suddenly an entire culture based on familial love, devotion, the capacity for mutual sacrifice, collapses. Nothing is possible in such a universe, and that is precisely what the tortures know".

"It is hard to be a survivor. It is hard to remember and tell this story, but I reappeared because people worked... Now I cannot let the others down".

Widespread Prevalence

Apart from its routine employment in war, torture is now being increasingly sanctioned by governments against peacetime 'subversion'. This form of official sanction is often combined with suspension of basic human rights and legal procedures; or else executed through quasi-governmental 'intelligence' groups over which direct government responsibility is disclaimed. Another alarming factor is the emergence of clear military/police training programmes on 'interrogation techniques', such as at the International Police Academy of the Agency for International Development at Washington, DC.

The book mentions cases of torture reported from the Algerian War (French), Vietnam War (by all parties), El Salvador, Guatemala, Indonesia; 'disappearances' and torture are reported from Afghanistan, Argentina, Bolivia, Burundi, Cambodia, Central African Empire, Chile, East Timor, Ethiopia, Iran, Peru, Philippines, Syria and Uganda. References to psychiatric abuse (PA) in Rumania, Uruguay, USA, Japan and USSR (which has been particularly indiated) are included; as well as documented involvement of HPs in abuse in Rome, Japan, Chile, Mauritania, Portugal, Sudan, Iran, Greece, USA and

USSR. Cases of conflict between HPs and governments and the issue of putting to practice codes of medical ethics have been considered from Chile, Uruguay, Brazil and South Africa. The book, however, distinctly focuses on physical abuse in Latin America and psychiatric abuse in USSR... because abuse is particularly widespread, systematic and well-documented in them".

Compiled evidence indicates that the role of HPs may include: Medical examinations at various stages: Attendance at torture sessions to intervene when the victim's life is threatened; treatment and 'patch-up' of injuries; development/refining of torture techniques and sometimes, administration of torture; and false certification of subjects for various reasons.

The participation of HPs in TPA clearly violates three basic tenets of medical ethics: (1) To do more good than harm; (2) To intervene only when the patient is willing and (3) To render treatment regardless of political or other considerations. This disregard of medical ethics cannot be justified in moral terms as serving any higher social purpose, as the book clearly shows through consideration of the commonly applied principles of justice, benevolence and autonomy.

The utilitarian argument for torture sanctions its limited use if it produces more good than evil; such as, say, against terrorists who may destroy hundreds of innocent lives. Such a position is difficult to achieve in practise, as its inefficiency and inefficacy have been regularly remarked up on. The 'good' result is a hypothetical probability, often not realised. More importantly, the applicability of such a rule is not clear. Known terrorists must be tortured. Can we torture their family, friends, neighbours, uncertain acquaintances? Clearly, the good that may be achieved is dwarfed by the evils imposed by a state-sanctioned system, which brutalises many ordinary people wielding some power—army, police, 'intelligence' people; associated medical and legal people, administrators—and corrodes the roots of civilised society.

One argument the book seems to have missed is regarding the context in which such a utilitarian argument is propounded—as a dubious means towards unworthy ends. 'Subversion', 'dissent', 'terrorism', 'war'—these are usually the result of an unsatisfactory political system—and the right thing to address would be the correction of this cause, rather than the sanction of a new evil in support of the one existing.

Research indicates that some torture victims suffer symptoms similar to concentration camp survivors and prisoners of war ((POWs): long-term physical and emotional trauma-heightened anxiety, recurrent nightmares, phobias that sometimes require counseling and treatment. It is also apparent that emotional problems increase on the torture victims emigrating to a new country and culture. Accounts of torture victims remind us that brutality can never be comprehended or measured in the abstract. It is a succession of personal tragedies, disabling to the individuals involved and destructive to humankind.

HPs, employers and other persons who interact with victims of torture need to be aware of and understand the consequences of TPA on the life of victims who will otherwise continue to be victims of misdiagnosis, inappropriate medical and psychiatric care, of preventable job stress and discrimination, of marital and family disruption, and of avoidable suicide.

The book outlines two studies on former torture victims—one covering 44 persons now settled in seven cities of the USA, the other 41 people in Toronto. Standard research protocols for physical and psychological evaluation were established. Those, and other similar studies, indicate a broadly consistent range of after effects in the majority of victims; objective evidence of physical damage in inverse proportion to the period of time elapsed; more widespread long-term psychological disturbances ranging from nervousness to post-traumatic stress disorder. Therefore, many psychologists argue for the establishment of specific diagnostic criteria for a 'torture syndrome'. While this will prevent the overlooking of the psychological difficulties of the victims, other psychologists argue that this might also result in labelling and stigmatisation of victims, particularly those who have come to terms with their experiences.

The book outlines criteria for provision of appropriate psychiatric service—underscoring the importance of rebuilding trust in human values, expunging 'situational guilt', assisting in the victims 'struggle for meaning', and cushioning the effects of rehabilitation into a new society and culture.

Psychiatric Abuse in USSR

Doubtless, PA is employed by intelligence agencies, particularly military, the world over. The book examines in detail the various factors (and the capability of HPs) that have led to the existence of a seemingly institutionalised system in the USSR.

Psychiatric internment for political purposes in Russia started somewhere in the 1930s. It gathered political sanction during the Khruschev period. A series of scandals in the 1970s resulted in worldwide concern and debate, culminating in the bowing out of the Soviet body, the All-union Society, from the World Psychiatric Association (WPA) in January 1983. (The society has recently been re-admitted to the WPA). However, there has been concern that while admitting maladministration of psychiatric care, the USSR has detracted attention from its political misuse, which is probably bound to continue. While many political victims have been freed from psychiatric prisons and there has been an announcement that all other political prisoners would be released from jail (*Indian Post*

October 27 1988, p 1) there is evidence of new cases of internment during the past two years.

Some psychologically healthy dissenters and human rights (HR) activists in the USSR are labelled mentally ill and subject to compulsory hospitalisation and 'treatment'. It is argued that the Soviet approach to psychiatric diagnosis, particularly the concept of schizophrenia, is a critical factor in labelling dissent as mental illness. Such activity is not simply conformance to the prevailing political system by one sympathetic part of the health bureaucracy. It would appear that psychiatric theory and practise have been systematically bent in the USSR for this purpose—a large-scale, cross-cultural WHO study showed that Soviet psychiatrists have a broader concept of schizophrenia and a unique system of categorisation that differs from that of other psychiatrists worldwide. The Sovieztinevsley school which dominates Soviet psychiatry is "... characterised by extremely broad diagnostic criteria, extreme schematism in classification and overwhelming pessimism in prognosis". It postulates that schizophrenia is genetic in origin, irreversible and deep-seated.

The forensic (legal) implications of the Soviet view are also far-reaching. It states that "schizophrenia is a disease in which patients are, with rare exceptions, deemed not responsible (for their behaviour)". Further, with the extremely broad conception of the disease, it is possible that the defendant, who is normal on examination, is still harbouring severe illness.

State-sanctioned torture can become a malignancy of the body-politic. The political system, professional group, public opinion and individual values—these establish norms of conduct, and normally these norms do not conflict. The fact that professionals face dilemmas when conflict occurs underscores the importance of developing ethical standards. An epidemiolocal approach, such as exists in the form of a national network in the US to study the social 'causation' and medico-social implications of murder, is suggested.

Since the people who stand to benefit from TPA are usually those in political positions to sustain it; preventive strategies must be aimed at those in power. Protection of human right is based on three methods: pressure by the international community; actions by national judicial system; and enforcement by international or regional bodies (such as the UNHCR).

Governments bear the 'shame of exposure'. Systematic collection of information by national groups is important. The International Committee of the Red Cross (ICRC) has probably the most detailed information worldwide; visiting prisoners worldwide to check on detention conditions as specified in the Geneva Convention. The International Medical Commission for Health in Human Rights (Geneva) could probably coordinate a data network on epidemiology, suggest the editors in their concluding chapter.

Research on how and why reasonably normal people get co-opted into perverse practises is also important. R.J. Lifton has suggested that one of the key concepts underlying Nazi medical killings was belief in the legitimacy of destroying 'life unworthy of life'. Lifton suggests that the Auschwitz doctors sometimes experienced ethical conflicts but were able to resolve them through a process of 'doubling'—creating an 'Auschwitz self' as well as a humance-husband father self—even as they killed, they held on to the idea that they were healers.

Medicine has become part of society's explicit political response to the general predicament of humans. Medicine is now an institutionalised social instrument employed for the general political purposes of the community—regulating birth and mortality rates, controlling epidemics, etc. In the circumstances, HPs have a positive duty to protect its ethical tenets. As the book states—we are now technically capable of treating bodies and minds effectively on a large scale. To put Orwell's fears of 1984 behind us, we must put medical ethics and internationally defined human right in front of us.

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(Cont. from page 67)

Concerning the erroneous demand of 'loyalty', in *Rafael Bielsa's* book *La funcion publica*, (Ed, Depalma, Buenos Aires, 1960, p. 34.) (Public duties) we read as follows: "The meaning of collaborating in public administration is not that of a partnership where everything must be accepted and legitimised. On the country, it implies checking, revision, objections, observations, and even well-founded opposition to any illegal or inappropriate act contrary to public interest." All professions should have a certain autonomy enabling them to resist pressures from the political systems in which they operate.

Finally, let us be united in our intentions and as physicians recall this statement from the Declaration of Geneva: "I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity."

Let this be poignantly rooted in our consitences so that society and all its institutions and organs can not accept the practice of torture in their midst ever to happen again. Likewise, let it no longer be allowed that physicians alienated from their medical standards act as unconscious robots for the military in prower. ***Let us under no circumstances whatsoever permit the existence of statutes, enclaves, or hierarchies that engender posibilities for such barbarity.***

Human Rights Ethical Codes and Declarations

A. Statements by Professional Associations

(i) The World Medical Association (WMA)

Resolution on Physician Participation in Capital Punishment

Following concern about the introduction of an execution method (lethal injection) which threatened to involve doctors directly in the process of execution, the WMA Secretary-General issued a press statement opposing any involvement of doctors in capital punishment. The 34th Assembly of the WMA, meeting in Libson some weeks after the issuing of the press statement, endorsed the Secretary-General's statement in the following terms:

Resolved, that the Assembly of the World Medical Association endorses the action of the Secretary General in issuing the attached press release on behalf of the World Medical Association condemning physician participation in capital punishment.

Further resolved, that it is unethical for physicians to participate in capital punishment, although this does not preclude physicians certifying death.

Further resolved, that the Medical Ethics Committee keep this matter under active consideration.

Secretary General's Press Release.

The first capital punishment by intravenous injection of lethal dose of drugs was decided to be carried out next week by the court of the state of Oklahoma, USA.

Regardless of the method of capital punishment a state imposes, no physician should be required to be an active participant. Physicians are dedicated to preserving life.

Acting as an executioner is not the practice of medicine and physician services are not required to carry out capital punishment even if the methodology utilizes pharmacological agents or equipment that might otherwise be used in the practice of medicine.

A physician's only role would be to certify death once the State had carried out the capital punishment.

September 11, 1981

Regulations in Time of Armed Conflict

These regulations or guidelines set out the WMA's standards on the medical ethical position of the physician during a period of war or other armed conflict. The statement was approved by the 10th World Medical Assembly in Havana in 1956, was edited by the 11th Assembly meeting in Istanbul the following year and was amended by the 35th World Medical Assembly in 1983.

The ameded text reads as follows:

1. Medical ethics in time of armed conflict is identical to medical ethics in time of peace, as established in the International Code of Medical Ethics of the World Medical Association. The primary obligation of the physician is his professional duty; in performing his professional duty, the physician's supreme guide is his conscience.

2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:

   A. Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable in the patient's interest.
   B. Weaken the physical or mental strength of a human being without therapeutic justification.
   C. Employ scientific knowledge to imperil health or destroy life.

3. Human experimentation in time of armed conflict is governed by the same code as in time of peace; it is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.

4. In emergencies, the physician must always give the required care impartially and without consideration of sex, race, nationality, religion, political affiliation or any other similar criterion. Such medical assistance must be continued for as long as necessary and practicable.

5. Medical confidentiality must be preserved by the physician in the practice of his profession.

6. Privileges and facilities afforded the physician must never be used for other than professional purposes.

Rules governing the care of sick and wounded, particularly in time of conflict

A. 1. Under all circumstances, every person, military or civilian must receive promptly the care he needs without consideration of sex, race, nationality, religion, political affiliation or any other similar criterion.
   2. Any emergencies, physicians and associated medical personnel are required to render immediate service to the best of their ability. No distinction shall be made between patients except those justified by medical urgency.

B. 1. In emergencies, physicians and associated medical personnel are required to render immediate service to the best of their ability. No distinction shall be made between patients except those justified by medical urgency.
   2. The members of medical and auxiliary professions must be granted the protection needed to carry out their professional activities freely. The assistance necessary should be given to them in fulfilling their responsibilities. Free passage should be granted whenever their assistance is required. They should be afforded complete professional independence.
   3. The fulfillment of medical duties and responsibilities shall in no circumstances be considered an offence. The physician must never be prosecuted for observing professional secrecy.

In fulfilling their professional duties, the medical and auxiliary professions will be identified by the distinctive emblem of a red serpent and staff on a white field. The use of this emblem is governed by special regulation.

Declaration of Tokyo

The Declaration of Tokyo has, since its adoption in 1975, been the most comprehensive statement produced by the medical profession on the question of the torture and cruel, inhuman or degrading treatment of detainees. It was adopted by the 29th World Medical Assembly, Tokyo, Japan.

The rest is as follows:

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his on her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined 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.

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other

forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether presonal, collective or political shall prevail against this higher purpose.

5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors, to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

(ii) World Psychiatric Association (WPA)

Declaration of Hawaii

In early 1976 work commenced on the drafting of an international code of thics for psychiatrists which was subsequently adopted in 1977 at the VI World Congress of Psychiatry in Honolulu, Hawaii. At the same meeting the WPA committed itself to receive and investigate allegations of the abuse of psychiatry for political purposes; in 1979 the establishment of the Review Committee was finalised and it first met in Paris in February 1980.

The constitutional status of the Review Committee was changed at the VII Congress in Vienna in July 1983 when it was made permanent and had its remit widened.

Minor amendments to the text of the Declaration were agreed at the July 1983 Congress. The text, as amended, reads as follows:

Ever since the dawn of culture, ethics has been an essential part of the healing art. It is the view of the World Psychiatric Association that due to conflicting loyalties and expectations of both physicians and patients in contemporary society and the delicate nature of the therapist-patient relationship, high ethical standards are especially important for those involved in the science and practice of psychiarty as a medical specialty. These guidelines have been delineated in order to promote close adherence to those standards and to prevent misuse of psychiatric concepts, knowledge and technology.

Since the psychiatrist is a member of society as well as a practitioner of medicine, he or she must consider the ethical implications specific to psychiatry as well as ethical demands on all physicians and the social responsibility of every man and woman.

Even though ethical behaviour is based on the individual psychiatrist's conscience and personal judgment, written guidelines are needed to clarify the profession's ethical implications.

Therefore, the General Assembly of the World Psychiatric Association has approved these ethical guidelines for psychiatrists, having in mind the great differences in cultural background, and in legal, social and economic conditions which exist in the various countries of the world. It should be understod that the World Psychiatric Association views these guidelines to be requirements for ethical standards of the psychiatric profession.

1. The aim of psychiatry is to treat mental illness and to promote mental health. To the best of his or her ability, consistent with accepted scientific knowledge and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources. To fulfil these aims requires continuous research and continual education of health care personnel, patients and the public.

2. Every psychiatrist should offer to the patient the best available therapy to his knowledge and if accepted must treat him or her with the solicitude and respect due to the dignity of all human beings. When the psychiatrist is responsible for treatment given by others he owes them competent supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help of another colleague.

3. The psychiatrist aspires for a therapeutic relationship that is founded on mutual agreement. At its optimum it requires trust, confidentiality, co-operation and mutual responsibility. Such a relationship may not be possible to establish with some patients. In that case, contact should be established with a relative or other person close to the patient. If and when a relationship is established for purposes other than therapeutic such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.

4. The psychiatrist should inform the patient of the nature of the condition, therapeutic procedures, including possible alternatives, and of the possible outcome. This information must be offered in a considerate way and the patient must be given the opportunity to choose between appropriate and available methods.

5. No procedure shall be performed nor treatment given against or independent of a patient's own will, unless, because of mental illness, the patient cannot form a judgement as to what is in his or her best interest and without which treatment serious impairment is likely to occur to the patient or others.

6. As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from the compulsory nature of the treatment and if further therapy is necessary should obtain voluntary consent. The psychiatrist should inform the patient and/or relatives or meaningful others, of the existence of mechanisms of appeal for the detention and for any other complains related to his or her well-being.

7. The psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment. The psychiatrist must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate.

8. Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient relieves the psychiatrist from this obligation, or to prevent serious harm to self or others makes disclosure necessary. In these cases, however, the patient should be informed of the breach of confidentiality.

9. To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when a case-history is released for scientific publication, whereby all reasonable measures must be taken to preserve the dignity and anonymity of the patient and to safeguard the personal reputation of the subject. The patient's participation must be voluntary, after full information has been given of the aim, procedures, risks and inconveniences of a research project and there must always be a reasonable relationship between calculated risks or inconveniences and the benefit of the study. In clinical research every subject must retain and exert all his rights as a patient. For children and other patients who cannot themselves given informed consent, this should be obtained from the legal next-of-kin. Every patient or research subject is free to withdraw for any reason at any time from any voluntary treatment and from any teaching or research programme in which he or she participates. This withdrawal, as well as any refusal to enter a programme, must never influence the

psychiatrist's efforts to help the patient or subject.

10. The psychiatrist should stop all therapeutic, teaching or research programmes that may evolve contrary to the principles of this Declaration.

(iii) The International Council of Nurses (ICN)

Role of Nurse in Care of Detainees and Prisoners

At the meeting of the Council of National Representatives of the International Council of Nurses in Singapore in August 1975, the following statement was adopted:

Whereas the ICN Code for Nurses specifically states that:

1. "The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering.
2. "The nurse's primary responsibility is to those people who require nursing care.
3. "The nurse when acting in a professional capacity should at all times maintain standards of personal conduct which reflect credit upon the profession.
4. "The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other persons;"

and

WHEREAS in 1973 ICN reaffirmed support for the Red Cross Rights and Duties of Nurses under the Geneva Conventions of 1949, which specifically state that, in case of armed conflict of international as well as national character (i.e. internal disorders, civil wars, armed rebellions):

1. Members of the armed forces, prisoners and persons taking no active part in the hostilities

(a) Shall be entitled to protection and care if wounded or sick,
(b) Shall be treated humanely, that is:
— they may not be subjected to physical mutilation, or to medical or scientific experiments of any kind which are not justified by the medical, dental or hospital treatment of the prisoner concerned and carried out in his interest,
— they shall not be wilfully left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created,
— they shall be treated humanely and cared for by the Party in conflict in whose power they may be, without adverse in conflict in whose power they may be, without adverse distinction founded on sex, nationality, religion, political opinion, or any other similar criteria.

2. The following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above mentioned persons:

(a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
(b) outrages upon personal dignity, in particular humiliating, and degrading treatment.

WHEREAS in 1971 ICN endorsed the United Nations Universal Declaration of Human Rights and, hence, accepted that:

1. "Everyone is entitled to all the rights and freedoms, set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Art.2),
2. "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Art.5)"; and

WHEREAS in relation to detainees and prisoners of conscience, interrogation procedures are increasingly being employed which result in ill effects, often permanent, on the person's mental and physical health;

THEREFORE BE IT RESOLVED that ICN condemns the use of all such procedures harmful to the mental and physical health of prisoners and detainees; and

FURTHER BE IT RESOLVED that nurses having knowledge of physical or mental ill-treatment of detainess and prisoners take appropriate action including reporting the matter to appropriate national and/or international bodies; and

FURTHER BE IT RESOLVED that nurses participate in clinical research out on prisoners, only if the freely given consent of the patient has been secured after a complete explanation and understanding by the patient of the nature and risk of the research; and

FINALLY BE IT RESOLVED that the nurse's first responsibility is towards her patients, notwithstanding considerations of national security and interest.

Nurse's Role in Safeguarding Human Rights

Responding to requests from national member associations for guidance on the protection of human rights of both nurses and those for whom they care, the Council of National Representatives of the International Council of Nurses adopted the statement given below at its meeting in Brasilia in June 1983.

This document has been developed in response to the requests of national nurses assosiations for guidance is assisting nurses to safegurads their own human rights and those for whom they have professional responsibility. It is meant to be used in conjunction with the ICN Code for Nurses and resolution relevant to human rights. Nurses should also be familiar with the Geneva Conventions and the additional protocols as they relate to the responsibilities of nurses.

The current world situation is such that there are innumerable circumstances in which a nurse may become involved that require action on her/his part to safeguard human rights. Nurses are accountable for their own professional actions and must therefore be clear as to what is expected of them in such situations.

Also conflict situations have increased in number and often include internal political upheaval, and strife, or international war. The nature of war is changing. Increasingly nurses find themselves having to act or respond in complex situations to which there seems to be no clear cut solution.

Changes in the field of communications also have increased the awareness and sensitivity of all groups to those conflict situations.

The need for nursing actions to safeguard human rights is not restricted to times of political upheaval and war. It can also arise in prisons or in the normal work situation of any nurse where abuse of patients, nurses, or others is witnessed or suspected. Nurses have a responsibility in each of these situations to take action to safeguard the rights of those involved. Physical abuse and mental abuse are equally of concern to the nurse. Over or under-treatment is another area to watched. There may be pressures applied to use one's knowledge and skills in ways that are not beneficial to patients or others.

Scientific discoveries have brought about more sophisticated forms of torture and methods of resuscitation so that those being tortured can be kept alive for repeated sessions. It is in such circumstances that nurses must be clear about what actions they must take as in no way can they participate in such torture, or torture techniques.

Nurses have individual responsibility but often they can be more effective if they approach human rights issues as a group. The national nurses associations need to ensure that their structure provides a realistic mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with these difficult situations. Verification of the facts reported will be an important first step in any particular situation.

At times it will be appropriate for the NNA to become a spokesman for the nurses involved. They may also be required to negotiate for them. It is *essential* that confidentality be maintained. In rare cases the personal judgment of the nurse may be such that other actions seem more appropriate than approaching the association.

The nurse initiating the actions requires knowledge of her own and other's human rights, moral courage, a well thought through plan of action and commitment and determination to see that the

ncessary follow-up does occur. Personal risk is a factor that has to be considered and each person must be use her/his best judgment in the situation.

Rights of Those in Need of Care

Health care is a right of all individuals. Everyone should have access to health care regardless of financial, political, geographic, racial or religious considerations. The nurse should seek to ensure such impartial treatment.

Nurses must ensure that adequate treatment is provided—within available resources—and in accord with nursing ethics (ICN Code) to all those in need of care.

A patient/prisoner has the right to refuse to eat or to refuse treatments. The nurse may need to verify that the patient/prisoner understands the implications of such action but she should not participate in the administration of food or medications to such patients.

Rights and Duties of Nurses

When considering the rights and duties of nursing personnel it needs to be remembered that both action and lack of action can have a detrimental effect and the nursing personnel must be considered accountable on both counts.

Nurses have a right to practise within the code of ethics and nursing legislation of the country in which they practice. Personal safety—freedom from abuse, threat or intimation—are the rights of every nurse.

National nurses assosiations have a responsibility to participate in development of health and social legislation relative to patient's rights and all related topics.

It *is a duty* to have informed consent of patients relative to having research done on them and in receiving treatments such as blood transfusions, anesthesia, grafts etc. Such informed consent is a patient's right and must be ensured.

(iv) Psychologist:

Statement by International Union of Psychological Science

In July 1976, the Assembly of the International Union of Psychological Science unanimously approved the statement of the Executive Committee of the International Union of Psychological Science made in July 1974.

The text is as follows:

The International Union of Psychological Science

which includes national psychological societies of 42 nations from all over the world;

which thus speaks in the name of over 70,000 professional psychologists who, because the subject of their science is behaviour, are particularly concerned with any acts by which individuals in a systematic and deliberate way infringe upon the inviolable rights of human beings, regardless of race, religion on ideology, these rights being guaranteed by the Charter of the United Nations;

and which is concerned with strict observance of professional standards of ethics in the practice of psychology,

therefore makes the following declarations:

It proclaims that no psychologist, in the exercise of his or her professional functions, should accept instructions or motivations that are inspired by considerations that are foreign to the profession; It protests solemnly against any use of scientific data or of professional methods of psychology that impair the abovementioned rights;

It formally condemns any collaboration by psychologists—whether actively or passively, directly or indirectly—with the abovementioned aubses, and it urges its members to oppose any abuses of this sort;

It requests each member-society to make certain that it has enacted a code of ethics and to take those actions required by its code against any member guilty of such abuses against human rights; It declares that the Executive Committee of IPUS is ready to support, with all means at its disposal, any action undertaken by a member-society in order to carry out the terms of the present resolution; It recalls the following statement made by its Executive Committee on July 27 1974: "The Executive Committee wishes to make clear that the International Union of Psychological Science denounces vigorously all practices that are contrary to the high level of morality that must regulate the scientific and professional roles assumed by psychologists in modern society."

It welcomes the United Nation's Resolution, adopted by the General Assembly (Third Committee: A/10408; 243rd plenary meeting, December 9, 1975) on the Protection of All Persons from being subjected to Inhuman Treatment.

B. United Nations Declarations and Codes

Principles of Medical Ethics

The principles are elaborated within the text of Resolution 37/194 adopted by the United Nations General Assembly, 18 December 1982.

The General Assembly...

Desirous of setting further standards in this field which ought to be implemented by health personnel, particularly physicians, and by government officials,

1. ADOPTS the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment on punishment set forth in the annex to the present resolution;.
2. CALLS UPON all governments to give the Principles of Medical Ethics, together with the present resolution, the widest possible distribution, in particular among medical and paramedical associations and institutions of detention or imprisonment in an official language of the State;
3. INVITES all relevant inter-governmental organisations, in particular the World Health Organisation, and non-governmental organisations concerned to bring the Principles of Medical Ethics to the attention of the widest possible group of individuals, especially those active in the medical and paramedical field.

Principles of Medical Ethics Relevant to Role of Health Personnel, Particularly Physicians, in Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Principle 1

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

Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.[1]

Principle 3

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

Principle 4

It is a contravention of medical ethics for health personnel, particularly physicians:.

a) to apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments;[2]

b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, or his fellow prisoners or detainees, or of his guardians, and present no hazard to his physical or mental health.

Principle 6

There may be no derogation from the foregoing principles on any grounds whatsoever, including public emergency.

Notes

1) *See the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman on Degrading Treatment or Punishment (General Assembly Resolution 3452 (XXX), annex), article 1 of which states:*

1."For the purpose of this declaration, torture means any act by which severe pain or suffering, whether physical or mental, is internationally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him on a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

2. "Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment."

Article 7 of the Declaration States:

"Each State shall ensure that all acts of torture as defined in article 1 are offences under its criminal law. The sale shall apply in regard to acts which constitute participation in, complicity in, incitement to or an attempt to commit torture."

2) *Particularly the Universal Declaration of Human Rights (General Assembly resolution 217 A (III), the International Convenants on Human Rights (General Assembly resolution 2200 A (XXI), annex), the Declaration on the Protection of all Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (General Assembly resolution 3452 (XXX), annex) and the Standard Minimum Rules for the Treatment of Prisoners (First United Nations Congress on the Prevention of Crime and the Treatment of Offenders: report by the Secretariat (United Nations publication, Sales No. 1956. IV.4), annex I.A).*

C. Amnesty International Declarations

Declaration on Participation of Doctors in Death Penalty 1981

Amnesty International,

Recalling

that the spirit of the Hippocratic Oath enjoins doctors to practise for the good of their patients and never to do harm,

Considering

that the Declaration of Tokyo of the World Medical Association provides that "the utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity",

Further Considering That

the same Declaration forbids the participation of doctors in torture or other cruel, inhuman or degrading treatments,

Noting

the the United Nations Secretariat has stated that the death penalty violates the right to life and that it constitutes cruel, inhuman or degrading treatment,

Mindful

that doctors can be called on to participate in executions by, *inter alia*,

—determining mental and physical fitness for execution,

—giving technical advice,

—prescribing, preparing, administering and supervising doses of poison in jurisdictions where this method is used,

—making medical examinations during executions, so that an execution can continue if the prisoner is not yet dead,

Declares

that the participation of doctors in executions is a violation of medical ethics;

Calls Upon

medical doctors not to participate in executions;

Further Calls Upon

medical organisations to protect doctors who refuse to participate in executions, and to adopt resolutions to these ends.

This declaration was formulated by the Medical Advisory Board of Amnesty International and was adopted by Amnesty International's International Executive Committee on March 12, 1981.

Conference on Abolition of Death Penalty Declaration of Stockholm

The Stockholm Conference on the Abolition of the Death Penalty, composed of more than 200 delegates and participants from Africa, Asia, Europe, the Middle East, North and South America and the Caribbean region,

Recalls That:

The death penalty is the ultimate cruel, inhuman and degrading punishment and violates the right to life.

Considers that:

—The death penalty is frequently used as an instrument of repression against opposition, racial, ethnic religious and underprivileged groups,

—Execution is an act of violence, and violence tends to provoke violence,

—The imposition and infliction of the death penalty is brutalising to all who are involved in the process,

—The death penalty has never been shown to have a special deterrent effect,

—The death penalty is increasingly taking the form of unexplained disappearances, extra-judicial executions and political murders,

—Execution is irrevocable and can be inflicted on the innocent.

Affirms that:

—It is the duty of the state to protect the life of all persons within its jurisdiction without exception,

—Executions for the purposes of political coercion, whether by government agencies or others, are equally unacceptable,

—Abolition of the death penalty is imperative for the achievement of declared international standards.

Declares:

—Its total and unconditional opposition to the death penalty,

—Its condemnation of all executions, in whatever form, committed or condoned by government,

—Its commitment to work for the universal abolition of the death penalty.

Calls upon:

—Non-governmental organisations, both national and international, to work collectively and individually to provide public information materials directed towards the abolition of the death penalty,

—All governments to bring about the immediate and total abolition of the death penalty,

—The United Nations unambiguously to declare that the death penalty is contrary to internatioinal law.

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This periodical is a collective effort of many individuals active or interested in the field of health or interested in health issues. The chief aim of the journal is to provide a forum for exchange of ideas and for generating a debate on practical and theoretical issues in health from a **radical or Marxist** perspective. We believe that only through such interaction can a coherent radical and marxist critique of health and health care be evolved.

Each issue of the journal highlights one theme, but it also publishes (i) Discussions on articles published in earlier issues (ii) Commentaries, reports, shorter contributions outside the main theme.

Our forthcoming issues will focus on : Medical Technology, Agricultural Development and Health, Health in People's Movements.

If you wish to write on any of these issues do let us know immediately. We have to work three months ahead of the date of publication which means that the issue on Medical Technology is already being worked on. A full length article should not exceed 6,000 words and the number of references in the article should not exceed 50. Unless otherwise stated author's names in the case of joint authorship will be printed in alphabetical order. You will appreciate that we have a broad editorial policy on the basis of which articles will be accepted.

We have an author's style-sheet and will send it to you on request. Please note that the spellings and referencing of reprint articles are as in the original and are NOT as per our style.

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All articles should be sent in duplicate. They should be neatly typed in double spacing on one side of the sheet. This is necessary because we do not have office facilities here and the press requires all material to be typed. But if it is impossible for you to get the material typed, do not let it stop you from sending us your contributions **in a neat handwriting** on one side of the paper. Send us two copies of the article written in a legible handwriting with words and sentences liberally spaced.

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Declaration Against Torture

The Declaration on the Protection of all Persons from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration against Torture) was adopted without a vote by the United Nations General Assembly on 9 December 1975. It calls upon states to take effective measures to prevent torture and lists some of the most important safeguards and remedies to be provided. It is one of the most important international documents on torture.

Declaration on Protection of All Persons From Torture and Other Cruel, inhuman or Degrading Treatment or Punishment

The United Nations General Assembly adopted on December 9, 1975 a declaration condemning any act of torture or other cruel, inhuman or degrading treatment as "an offence to human dignity". Under its terms, no state may permit or tolerate torture or other inhuman or degrading treatment, and each state is requested to take effective measures to prevent such treatment from being practised within its jurisdiction.

The Declaration was first adopted and referred to the Assembly by the Fifth United Nations Congress on the Prevention of Crime and Treatment of Offenders, held in Geneva in September 1975. In adopting the Declaration without a vote, the Assembly noted that the Universal Declaration of Human Rights and the International Covenant on Civil Political Rights provide that no one may be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

The Assembly has recommended that the Declaration serve as a guideline for all states and other entities exercising effective power.

The text of the Declaration follows:

Article 1

1. For the purpose of this Declaration, torture means any act by which sevére pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to teh extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

2. Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment.

Article 2

Any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.

Article 3

No state may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment. Exceptional circumstances such as a state of war or a threat of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

Article 4

Each State shall, in accordance with the provisions of this Declaration, take effective measures to prevent torture and other cruel, inhuman or degrading treatment or punishment from being practised within its jurisdiction.

Article 5

The training of law enforcement personnel and of other public officials who may be responsible for persons deprived of their liberty shall ensure that full account is taken of the prohibition against torture and other cruel, inhuman or degrading treatment or punishment. This prohibition shall also, where appropriate, be included in such general rules or instructions as are issued in regard to the duties and functions of anyone who may be involved in the custody or treatment of such persons.

Article 6

Each state shall keep under systematic review interrogation methods and practices as well as arrangements for the custody and treatment of persons deprived of their liberty in its territory, with a view to preventing any cases of torture or other cruel, inhuman or degrading treatment or punishment.

Article 7

Each state shall ensure that all acts of torture as defined in article 1 are offences under its criminal law. The same shall apply in regard to acts which constitute participation in, complicity in, incitement to or an attempt to commit torture.

Article 8

Any person who alleges that he has been subjected to torture or other cruel, inhuman or degrading treatment or punishment by or the instigation of a public official shall have the right to complain to, and to have his case impartially examined by, the competent authorities of the state concerned.

Article 9

Wherever there is reasonable ground to believe that an act of torture as defined in article 1 has been committed, the competent authorities of the state concerned shall promptly proceed to an impartial investigation even if there has been no formal complaint.

Article 10

If an investigation under article 8 or article 9 establishes that an act of torture as defined in article 1 appears to have been committed, criminal proceedings shall be instituted against the alleged offender or offenders in accordance with national law. If an allegation of other forms of cruel, inhuman or degrading treatment or punishment is considered to be well founded, the alleged offender or offenders shall be subject to criminal, disciplinary or other appropriate proceedings.

Article 11

Where it is proved that an act of torture or other cruel, inhuman or degrading treatment or punishment has been committed by or at the instigationof a public official, the victim shall be afforded redress and compensation in accordance with national law.

Article 12

Any statement which is established to have been made as a result of torture or other cruel inhuman or degrading treatment may not be invoked as evidence against the person concerned or against any other person in any proceedings.