amnesty international

Involvement of medical personnel in abuses against detainees and prisoners
(revised and updated)

UN Principles of Medical Ethics

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.

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Involvement of medical personnel in abuses against detainees and prisoners

In countries where human rights abuses are widespread, doctors often do not have adequate access to prisoners in circumstances where they can act with clinical independence. In some cases however, medical personnel can see prisoners in situations where the prisoner is denied other protective contacts such as with legal counsel or with family. For this reason the doctor's role in safeguarding the health *and* the security of the prisoner is of considerable importance. Where human rights violations are not systematic or not even a major concern, the doctor still can play a protective role. In many countries however this protective role is negated by the failure of medical personnel to adhere to basic tenets of medical ethics[1].

The purpose of this report is to review the evidence available to Amnesty International that medical personnel are involved in human rights violations, to describe the ways in which this involvement occurs, and to give examples of some of those activities which, while legal under domestic law in some countries, constitute violations of human rights and can involve health professionals in infringements of medical ethics. Finally the argument for increased vigilance by the medical profession is presented.

Amnesty International's concerns

1 For general discussion see the Amnesty International paper *Medicine at Risk: the doctor as human rights abuser and victim.* AI Index: ACT 75/01/89, January 1989. While doctors are the principal focus of this paper, the involvement of nurses, psychologists and others - where they facilitate the violation of human rights - is of equal concern. In some countries and contexts, the health worker most likely to be under pressure to compromise his or her ethics may well be a nurse.

Amnesty International works for the freedom of prisoners of conscience, for prompt and fair trials for political prisoners and for an end to torture and executions. Its concerns regarding abuses by medical personnel thus focus on those activities which contribute to human rights violations falling within this mandate[2]. The reason for AI's particular concern about the involvement of health professionals in abuses derives from the following considerations:

- the ethical basis of medicine requires doctors to do good and to avoid doing harm; i.e. the ethics of the profession prohibits involvement in abuses
- international human rights and professional ethical standards[3] make clear that medical involvement in human rights violations is prohibited
- medical personnel can be subjected to subtle and overt pressures to assist prison or police personnel rather than their patients and this pressure needs to be recognised and dealt with
- doctors have special access to prisoners which allows them the potential to play a protective role towards the individual prisoner but, more widely, to contribute to the defence of human rights and medical ethical standards; equally it increases the potential negative effect of any failure to observe ethical principles.

These factors emphasise the special responsibilities of health personnel and lead AI to raise the issue of medical involvement as a serious issue requiring a concerted response from the health professions themselves, and from human rights and other non-governmental organizations, with the objectives of persuading those culpable to change their behaviour and governments to meet international human rights standards.

Sources of information

AI receives information on human rights abuses from diverse sources: prisoners and ex-prisoners and their families; lawyers; human rights activists; professional associations; exile groups; the press; radio broadcasts; government sources. AI attempts to verify information from independent sources as well as assessing the information in the light of what is known about human rights practices and individual cases in the country in question. In some cases of torture, AI is able to evaluate allegations by drawing on medical evidence made available to the organization.

Reports of medical involvement in human rights violations

2 Important discussions relating to subjects outside AI's mandate, such as ethical aspects of reproductive technologies or of health-related issues such as government funding of the health care system and unequal access to medical services are not within the scope of the organization.

3 See Amnesty International. *Ethical Codes and Declarations Relevant to the Health Professions.* AI Index 75/01/85, June 1985.

While allegations of torture can be assessed by a number of methods including medical examination, allegations of medical participation depend entirely on information given by those who have been exposed to torture. Such testimony therefore requires rigorous assessment before allegations of medical involvement can be accepted as valid. In making such evaluations it is important to take into account the fact that frequently information about medical involvement in abuses is given as an incidental component to torture testimony since to the victim of such treatment, the doctor was only one of many abusers and may not have appeared a significant figure. Moreover, in some cases the victim may have been blindfold or unable for other reasons to determine whether there was a doctor present; in other cases, the detainee may not have been able to judge whether a person carrying out a medical examination was indeed a doctor. However, AI is convinced that medical personnel do participate in torture and gives credence to much of the testimony it has received implicating doctors in abuses. In assessing such allegations AI takes into account a number of different factors. These include the following:

- Reports coming from different sources and clearly reflecting individual experiences tell a similar story and show a consistent and recognisable pattern. Allegations accord with what is known already about human rights violations in the country in question;
- In some cases detained doctors who have themselves been tortured or have been with prisoners who have been tortured have reported being examined by, or having contact with, someone they were convinced was a doctor;
- In some cases there is confirmation of medical involvement from reputable local human rights bodies or professional associations which have found convincing evidence implicating doctors in torture. A small number of doctors have been disciplined by their professional associations for such behaviour;

In addition, in rare cases, doctors are prosecuted in courts of law for involvement in torture.

In the case of executions and corporal punishments, the role of the doctor is peripheral to that of the agent of the punishment (though arguably the doctor plays an important legitimising role). Clear detail concerning medical activities in connection with the punishment is often not readily available to AI. Nevertheless, medical involvement in at least some cases is documented by eye-witness reports, by prisoners and the press (and of course in some countries the law specifies that a doctor should be present at the infliction of the punishment).

The scale of the problem

It is not possible to determine the number of individual abuses involving doctors nor the number of doctors involved in human rights violations around the world. Moreover, there is a problem in defining precisely what constitutes medical involvement. In both the USSR and Uruguay, for example, some commentators have suggested that there was widespread

knowledge in the profession that abuses were taking place - in USSR by psychiatrists, in Uruguay by military physicians - but there are differences about the point at which individuals could be regarded as culpable (as opposed to unwilling victims of the system)[4].

It is probable that the number of doctors consciously and deliberately engaging in torture and other cruel, inhuman and degrading treatment or punishment represents a tiny proportion of the profession. The numbers of those who are *aware* of the abuses which are carried out by against prisoners by police, security or prison officers (sometimes with the acquiesence or active involvement of this minority of medical personnel) is very probably much more substantial[5]. However, any estimate of numbers or proportions can only be guess-work at best. This paper focuses predominantly on active and deliberate commission of, or collaboration with, human rights violations.

Reasons for medical participation

Given the immense contradiction between the doctor's role as a healer and participation in gross cruelty, the apparent willingness of some medical personnel to participate in torture requires explanation. It is rare for doctors to talk about their own role in human rights violations[6] and therefore the reasons for medical participation can, for the most part, be the subject of speculation only. However, those participating in torture or other abuses will probably be doing so for one or more of the following reasons.

Identification with the cause of the torturers: Medical personnel working with security forces may absorb (or fundamentally identify with) the values of the agents who carry out the torture. This may be particularly the case when there are sharp political, social or racial divisions within a country.

Fear of the consequences of refusal: In some countries doctors have been forced to serve a period of military service and may have believed that opposition to military superiors was impossible. In some cases, doctors face contradictory obligations - for example to medical ethics and to legal strictures against the public exposure of abuses occurring in

4 See Bloche GM. *Uruguay's Military Physicians: Cogs in System of State Terror*, Washington: AAAS, 1987; Bloch S, Reddaway P. *Russia's Political Hospitals*, London: Gollancz, 1977; Reich W. The world of Soviet psychiatry. In: *The Breaking of Bodies and Minds* (ed. Stover E, Nightingale EO). New York: Freeman, 1985.

5 A report by the American Association for the Advancement of Science on medical involvement in torture in Chile, for example, was entitled *The Open Secret*(Stover E, 1987); the significance of the Chile example is that the Chilean Medical Association actively and persistently addressed itself to this problem and rooted out a number of guilty doctors.

6 A television program, *Doctors and Torture*, transmitted by the British Broadcasting Corporation on 12 September 1990, did include rare interviews with two doctors who had been disciplined by their medical associations in Brazil and Uruguay in connection with torture. Articles based on the television program were published in *The Daily Telegraph Weekend Magazine* [London], 8 September 1990, and *The Listener* [London], 13 September 1990.

government service.

"Bureaucratization" of the medical role: Some doctors appear to have been able to distance themselves from the abuses being inflicted on prisoners by adopting the role of uninvolved technician, carrying out a purely technical function.

Inadequate understanding of medical ethics: Some doctors may see their role as that of a healer minimizing the pain which is inevitably a consequence of torture or ill-treatment. This may be particularly so in the case of capital and corporal punishments where there is a legal framework in which the medical role is played out[7].

Ethical standards

There are numerous national and international standards which regulate the behaviour of medical personnel with respect to detainees and prisoners. Of the international standards, the most significant standards deriving from the professions themselves are the *Declaration of Tokyo* of the World Medical Association (adopted 1975), the *Declaration of Hawaii* of the World Psychiatric Association (adopted 1977), and the statement on the *Role of the Nurse in the Care of Detainees and Prisoners* of the International Council of Nurses (adopted 1975). At a regional level, an international meeting of medical associations and organizations adopted *European Principles of Medical Ethics* (January 1987) and the *Declaration of Kuwait* was adopted by an International Conference on Islamic Medicine in 1981 (1401 in the Islamic calendar); both contain principles applicable to the doctor-prisoner relationship. In addition, there are other declarations and statements by international and regional associations on specific issues such as prison medicine and the death penalty[8].

Of the intergovernmental standards, the United Nations *Principles of Medical Ethics* (adopted by the UN General Assembly, December 1982) clearly states a prohibition on medical involvement in torture and other cruel, inhuman or degrading treatment or punishment[9].

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7 See *Medicine at risk: the doctor as human rights abuser and victim.* AI Index: ACT 75/01/89, February 1990; *Médecins tortionnaires, médecins résistants* (V. Marange and the French medical commission of Amnesty International). Paris: La Découverte, 1989 [Available in English as *Doctors and Torture.* London: Bellew, 1990]. For a discussion of medical involvement in gross human rights violations perpetrated in an earlier era, see Lifton RJ. *The Nazi Doctors*. London: Papermac, 1987.

8 These include statements by the International Council of Nurses on nurses and torture (adopted 1989) and the International Council of Prison Medical Services on prison medicine (adopted 1979). See Addendum to *Ethical Codes and Declarations Relevant to the Health Professions* AI Index: 75/01/85/Addendum, May 1990. Extracts in English of the Declaration of Kuwait are contained in the *World Medical Journal*, 1982, **29**:78-80.

9 See *Ethical Codes and Declarations Relevant to the Health Professions.* London: Amnesty International, AI Index: 75/01/85, 1985.

Recent developments

Over the past year there have been some significant developments with regard to deliberate infliction of, and medical involvement in, human rights violations. Firstly, with regard to standards, the United Nations Economic and Social Council has adopted a new set of standards on the investigation of certain kinds of deaths including those occurring in places of detention (see page 12 below). On a similar theme, the Committee on Legal Affairs and Human Rights of the Council of Europe decided to consider the possible harmonisation of autopsy procedures within the European Community. One of the factors taken into account in deciding this was the potential beneficial effect of such harmonised standards in combating human rights violations.

In 1989, two major international professional associations - the World Psychiatric Association and the International Council of Nurses - adopted resolutions against the death penalty which now means that the international medical, psychiatric and nursing bodies have all declared opposition to medical involvement in executions. In November 1989 the Standing Committee of Doctors of the European Community adopted a *Statement of Madrid* on doctors, ethics and torture which reiterated the need for wider adherence to existing standards. In a number of countries over recent years, medical and other professional associations have taken other initiatives to oppose human rights violations[10].

With regard to changes in human rights practices over the last year, the transfer of power in many Latin American countries to elected civilian governments has led to a dramatic fall-off in allegations of primary medical involvement in human rights violations.

Secondly, changes in Eastern Europe will probably make less likely the involvement of physicians in politically-motivated abuses of the kind reported in the past. In the USSR, AI continues to investigate a small number of cases (around 10) of psychiatric internment for political reasons. The indications are that should the changes in USSR law and practice continue to develop in the current direction, political abuse of psychiatry will be a much rarer, if not non-existent, phenomenon.

In Africa, many prisons are characterised by poor conditions including minimal medical care. Involvement of doctors in torture is uncertain but some are certainly involved in corporal punishment and executions in some countries. For example, physicians are required by law to evaluate and monitor prisoners for whipping. Recent information suggests that punishments provided for by *Shari'a* may be resumed in Sudan following the military coup of June 1989 with the prospect of medical involvement.

In the Middle East, corporal and capital punishment in Saudi Arabia, United Arab Emirates, Yemen Arab Republic (now joined with the People's Democratic Republic of Yemen to form the Republic of Yemen) and Iran continues to be a concern though the exact

10 It is not possible here to detail all initiatives taken by national medical and human rights bodies to oppose violations but some of these are discussed in *The Breaking of Bodies and Minds* (Stover E, Nightingale EO, eds). New York: Freeman, 1985. See also, *Médecins tortionnaires, médecins résistants, op. cit.*

role of doctors is uncertain. In Jordan, a proposal to abolish corporal punishment is reported to be under discussion.

In Asia, Malaysia, Singapore, Pakistan, and Brunei continue to sentence prisoners to corporal punishment (Pakistan within a framework of *Shari'a*). Medical supervision of the punishment is required[11].

Evidence of medical involvement

The evidence of medical participation in human rights abuses presented below comes substantially from AI's own publications and research information. However, it is important to acknowledge some other significant sources not referred to in depth here. The first is the body of reports and publications of human rights groups working in countries with serious human rights problems. Examples of these include the *Vicaria de la Solidaridad*, the *Fundacion de Ayuda de las Iglesias Cristianas* (FASIC), and the *Comision para la defensa de los Derechos del Pueblo* (CODEPU) in Chile[12]; and the Moscow Working Commission for the Investigation of the Political Abuse of Psychiatry which published bulletins regularly between 1977 and 1981[13].

The second type of source includes medical associations which have themselves investigated allegations of medical involvement in torture or other abuses and have taken disciplinary action against those doctors found guilty of such activities. Examples include the Uruguayan medical associations (the *Federacion Médica del Interior* and the *Sindicato Médico del Uruguay*)[14]; the Chilean Medical Association (*Colegio Médico de Chile*)[15]; and

11 Medical ethical standards prohibit participation by doctors in cruel, inhuman or degrading punishments. The United Nations Human Rights Committee, in its 'general comment' on Article 7 of the International Covenant on Civil and Political Rights, stated that the prohibition of torture and cruel, inhuman or degrading treatment or punishment "must extend to corporal punishment". Human Rights Committee. General Comments under Article 40, paragraph 4, of the International Covenant on Civil and Political Rights. General comment 7(16). UN Document CCPR/C/21/Add.1, July 1982.

12 The *Vicaria* produces a monthly magazine, *Solidaridad*, as well as annual reports; FASIC publishes an *Informe Anual de Actividades* as well as numerous reports from its medical team; CODEPU published a book in 1989 entitled *Persona, Estado, Poder* which summarized its work during the period of military rule in Chile and included discussion of medical involvement in torture.

13 The Working Commission stopped publishing in 1981 because by that time all its members had been arrested or gone into exile. See *Political abuse of psychiatry in the USSR*. AI Index: EUR 46/01/93, 9 March 1983.

14 Martirena G. *La Tortura y Los Médicos*. Montevideo: Ediciones de la Banda Oriental, 1988.

15 Rivas F. Doctor torturers penalized by their professional body in a country where torture is practised. *Danish Medical Bulletin*, 1987, **34**:191-2.

the Turkish Medical Association (*Türkiye Tabipleri Birligi*)[16].

The third type of source for information on medical abuses comes from professional and human rights organizations in North America and Europe, notably the American Association for the Advancement of Science[17], Physicians for Human Rights[18], the International Association on the Political Use of Psychiatry[19] and the Dutch Johannes Weir Stichting[20] with respect to particular countries, and the British Medical Association[21] and the Danish RCT[22] with respect to the theme of medical involvement in torture.

The following summary indicates some of the areas in which AI has received allegations of medical involvement over the past decade.

Torture

Medical involvement in torture ranges from the infliction of torture by doctors themselves, through acting as an advisor or medical supervisor of torture, to the false certification of health or of death after torture has been inflicted. In many cases, the behaviour of the doctor encompasses more than one of these roles.

Examination of prisoners before torture to indicate weaknesses or to note possible life-threatening problems, or direct infliction of torture

The role of the doctor in torture stems from his (rarely her) medical expertise. For that reason, the doctor appears to play an advisory or supervisory role during torture rather than to inflict torture personally. However, it is easy to see that the line between active infliction

16 *Ankara Tabip Odasi Bulteni*, 1989, No.6, p.47.

17 See the series on health professionals and human rights published in 1987: Bloche GM. *Uruguay's Military Physicians: Cogs in a System of State Terror*; Stover E. *An Open Secret*; Stover E, Lopez J, Claude R. *Health and Human Rights in the Philippines*; Rayner M. *Turning a Blind Eye?*. A recent report looked at the practice of medicine in South Africa under the policy of *apartheid*: *Apartheid Medicine: Health and Human Rights in South Africa*. Washington: AAAS, 1990.

18 See, for example, the PHR newsletter, *Record*,Vol.III, No.1 (Winter/Spring) 1990, for a report of allegations of a physician's collusion in beatings of prisoners in a prison in Yugoslavia.

19 IAPUP has regularly published an *Information Bulletin* since 1981 detailing political abuse of psychiatry in several countries.

20 van Es A, Gurp M. *Report on a Mission to South Africa*. Leiden: Johannes Weir Foundation, 1987.

21 British Medical Association. *The Torture Report*. London: BMA, 1986.

22 See, for example, RCT's *International Newsletter on Treatment and Rehabilitation of Torture Victims*, Vol.2, no.2, 1990.

of torture and assisting others to carry out torture is a fine one and doctors who are present during torture can easily slip from one role to the other. In some cases a "medical" activity such as administering medication by intravenous injection may appear to the prisoner to be threatening or even a form of torture, particularly if it is given without explanation or sympathy (and in some circumstances it *is* a form of torture such as when substances are administered in the absence of therapeutic need and with the intention to cause suffering).

Moreover, the vulnerability of the prisoner and the sense of betrayal which he or she experiences when confronted by a doctor who is working with torturers can itself amplify the suffering inflicted. An engineering student who was held in a clandestine prison in Argentina and tortured over several months in the late 1970s later recounted that on one of the two occasions he was seen by a doctor during his detention:

"samples of my urine were collected because one of my kidneys had been injured.

> I felt like an animal in a laboratory experiment, with a professional taking care of my vital functions but not of me as a human being".[23]

AI received evidence and numerous testimonies from prisoners and former prisoners from Latin America - notably Chile and Uruguay - and elsewhere that during the 1980s doctors examined prisoners to evaluate their health in order to assist torturers[24]. For example, in Chile for more than a decade ex-prisoners testified that medical examinations were made on arrival at the secret detention centre and at various times during their stay. One prisoner testified that after arrival at a detention centre he was taken to a room and stripped naked.

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23 Victims of torture: two testimonies [testimony of Carlos Sanabria]. In: *The Breaking of Bodies and Minds: Torture, Psychiatric Abuse and the Health Professions.* (eds. Stover E, Nightingale EO). New York: WH Freeman, 1985, pp.52-3.

24 Obviously, medical examinations of prisoners on arrival at a place of detention and at regular periods throughout their stay can be a *protection* for the prisoner if the doctor is willing and able to fulfil a protective role. The UN Special Rapporteur on torture noted in his 1988 report that "if a detainee is certified to be in sound condition at the moment of his arrest, it will be more difficult to explain why his health has deteriorated during his period of detention". This fact can function as a deterrent to abuses. For a discussion of the protective role of medical examinations in the context of allegations of ill-treatment by prisoners see: Amnesty International. *Egypt: Arbitrary Detention and Torture Under Emergency Powers*, AI Publications, 1989. One measure adopted by the Colegio Médico de Chile to help address the potential ambiguities of medical examinations of prisoners and to counter medical involvement in torture was to incorporate in their code of medical ethics clear instructions about the procedures for examinations. The code specifies when a doctor should refuse to cooperate with detaining authorities; how they should behave when required to see detainees; minimum standards of clinical freedom; and non-participation in interrogation sessions. See: Normas éticas relativas a la atención médica de detenidos [Ethical norms applying to medical attention for detainees]. In: *Médica Etica: Normas y Documentos*. Santiago: Colegio Medico de Chile, 1986. These are quoted in English in *Human rights in Chile: the role of the medical profession*, AI Index: AMR 22/36/86, 1986.

"Here the doctor examined me all over, measured my blood pressure and said: 'He is suffering from arterial hypertension', and other things I didn't understand...

I would like to point out that after the thorough medical examination carried out by the physician who authorized the torture and as a result of his diagnosis...the brutal beatings stopped."[25]

In Morocco, a prisoner alleged in 1986 that:

"A medical person was involved in the torture. I could see him. He helped the torturers to select the more sensitive parts of my body and said whether I could still stand the torture. He told me to confess so that the torture would end. Afterwards he gave me some medical treatment."[26]

Monitoring the health of the prisoner during torture

One obvious role of the doctor during torture is to prevent the death of the prisoner. A Uruguayan doctor who himself had been imprisoned in the 1970s told an interviewer that since he left prison he has not seen many prisoners with physical injuries related to torture. The torturers were, he said,

"... highly trained in methods of exacting the maximum pain without leaving any significant physical traces - and, for that matter, without killing the victim in the process. There were relatively few deaths under torture in Uruguay. This was because there were usually doctors in attendance at the sessions."[27]

In Turkey a former prisoner alleged that:

"in Metris, people talked about the fact that doctors were present during torture.... It was said that they were there to determine the moment when death was approaching and only then would they stop the torture."[28]

In Venezuela in March 1989, a person thought by detainees to be a doctor "stopped the [security] agents from being too rough after [a detainee] suffered respiratory attacks and prevented them from applying electric shocks".[29]

"Patching up" the prisoner after torture, either to allow more torture or to allow

25 Amnesty International. *Human rights in Chile: the role of the medical profession.* AI Index: AMR 22/36/86, 1986.

26 Amnesty International. *Morocco: Human rights violations in* garde à vue *detention.* AI Index: MDE 29/01/90, March 1990.

27 Quoted in: Weschler L. *A Miracle, A Universe.* New York: Pantheon, 1990, p.126.

28 Amnesty International. *Turkey: torture and medical neglect of prisoners.* AI Index: EUR 44/28/88, May 1988.

29 Amnesty International. *Venezuela: Reports of arbitrary killings and torture: February/March 1989.* AI Index: AMR 53/02/90, March 1990, p.12.

the prisoner to be seen publicly

AI has also received reports of medical examinations being given just prior to the appearance in court or the release of a prisoner, the objective of which appears to have been to ensure that the prisoner would appear to be fit and with minimum signs of torture. For example, a prisoner in Chile testified that:

"I was examined five times by the staff of the medical room.... Of course on the first four occasions the diagnosis was implacable: fit for torture. I suppose the fifth check-up was to make sure I was fit to be presented to the military prosecutor."[30]

False certification of the health of a prisoner or of cause of death

AI has documented the use of medical certificates to falsely indicate that the prisoner has been released from police custody in a healthy condition or that they died of natural causes rather than under torture. In some cases it is not clear whether certificates have been deliberately falsified or are incompetently prepared[31]. Sometimes, pressure is applied to medical personnel to withhold or to falsify evidence. For example, Cem Ali Temuçin was detained in Ankara on 1 March 1988. He was transferred to prison on 10 March and a medical report issued on that day described his health as good. However, four days later a second doctor examined him and found bruises and abrasions which had been inflicted while the prisoner was in police custody[32].

In 1986 a Turkish magazine reporting on the death of a detainee Hasan Hakki Erdogan on 30 September 1984 noted that the inquest report had taken 15 days to prepare because one of the three signatories had refused to endorse the report. However, the report was eventually signed.

"Referring to the inquest report, specialist Dr [name given] said: 'I did not prepare that report. It was prepared by my assistant Dr [name given]. I resisted signing it for a long time. I even went up to see the Head of Department, Professor Dr [name given]. He said: "In the communication we received,

30 Amnesty International. *Recent torture testimonies implicating doctors in abuses of medical ethics in Chile.* AI Index: AMR 22/29/84, 31 May 1984.

31 Examples of deliberate falsifications can be found in *Chile: Evidence of Torture.* AI Publications, 1983, and "Violating medical ethics", *Amnesty International Newsletter,* July 1985. Examples of negligence and deliberate falsification are given in *Brazil: Torture and Extrajudicial Executions in Urban Brazil.* AI Publications, 1990.

32 *Turkey: Amnesty International Briefing*, AI Publications, 1988. In a similar vein, another Turkish prisoner testified that after a visit by a doctor to police headquarters in Izmir during which he and others were not examined, "we later found out that a medical report had been issued stating that none of us bore traces of force as a possible result of blows and beatings". See: Amnesty International. *Turkey: torture and unfair trial of political prisoners.* EUR 44/101/89, October 1989.

there was mention of acute kidney failure and lung oedema. Let your report be in accordance with this. Sign it."; and I was forced to endorse it. It was really impossible for me to do anything there at the time."'[33]

The problem of inadequate or fraudulent forensic investigations and reports has been a subject of concern to human rights organizations and concerned forensic specialists and as a result of independent and UN-organized initiatives, the United Nations Economic and Social Council (ECOSOC) approved a resolution on the investigation of "suspicious" deaths in April 1989. A manual of forensic techniques applicable to such investigations is in preparation[34].

Abuses in hospitals

Occasionally there are reports of incursions into medical surgeries or hospitals. In the early 1980s there were several reports of armed men entering clinics in El Salvador and Guatemala and torturing and killing both patients and medical and nursing staff. In these cases available evidence suggests that these abuses occurred without medical complicity. More recently in Chile a 24-year-old Naval wireless operator, arrested in May 1988 in connection with the killing of a security agent, alleged that he had been tortured four times at the Naval Hospital in Valparaiso[35]. A report issued by the human rights group CODEPU alleged that medical staff assisted in this abuse[36].

Involvement in corporal punishment

Advising on, or carrying out, amputations

Punitive amputation appears to be a lawful punishment only in certain Islamic states. AI does not have exact figures on the number of amputations carried out but has documented the punishment occurring since 1980 in Mauritania, Sudan, Iran, Yemen Arab Republic[37] and Saudi Arabia. In Pakistan, sentences have been handed down, but not carried out, reportedly (at least in some instances) because no surgeon was willing to participate.

33 *Yeni Gundem* [Istanbul], 5-11 May 1986. [Translation by Amnesty International.]

34 ECOSOC Resolution 65/1989: *Effective prevention and investigation of extra-legal, arbitrary and summary executions*. The forensic manual is based on that elaborated by the Minnesota International Lawyers Committee for Human Rights in the period 1985-1989.

35 Amnesty International. *Medical concern: three prisoners in isolation in Chile.* AI Index: AMR 22/01/89, January 1989.

36 Ibacache L. Tortura en el hospital "Almirante Neff", Valparaiso. Mimeo. Paper presented at CODEPU meeting, Santiago, November 1989.

37 In 1990, the Yemen Arab Republic and the People's Democratic Republic of Yemen joined to form the Republic of Yemen. The new constitution of the unified Republic bans "inhuman methods" of punishment, though it remains to be confirmed that this includes amputations.

Evidence of the participation of doctors in such punishment is part circumstantial and part documented. For example, the involvement of doctors in the three amputations which took place in Mauritania in September 1980 is undisputed and evoked an expression of deep concern from the Mauritanian Association of Doctors, Pharmacists and Dentists; two amputations carried out in 1982 were executed by medical auxiliaries following refusal by doctors to participate. (A change of government by coup in 1984 saw an end to the application of *Shari'a*-based laws in criminal cases.)

The government of President Nimeiri in Sudan introduced laws based on *Shari'a* in 1983 and until its downfall in 1985 more than 100 sentences of amputation were imposed. The first of these sentences were closely supervised by a British-trained Sudanese surgeon. In an article published in a Toronto daily, he was quoted as saying:

"I devised the operation. I wanted the thing done quickly and without pain. I trained the guards in the prison where to give the local anaesthetic and how to clean the hand. I trained them how to use the surgical scalpel. I wanted it to be done so that the patient [sic] would not lose blood ....

I attended the first six or seven just to make sure my system was working all right, to see if there was anything to improve. I am very happy that it went without accident, not a single infection."[38]

According to information given to AI by a Sudanese doctor in 1984, at the first amputations, the doctor quoted above administered a local anaesthetic to the condemned after they had been given sedation (diazepam). Another source indicated that local ischaemia was induced by tourniquet prior to the amputation. The amputation was carried out by prison officers who had been trained in amputation skills using cadavers. Following the amputation, the prisoner was taken to a waiting ambulance and driven to a hospital where a surgical team was ready to deal with the stump.

In August 1982, the Iranian Government announced the conversion of the legal system into one based on Islamic law. Since that time, Amnesty International has received persistent reports of amputations carried out as punishment for certain offences[39]. Reuters news agency, quoting a Tehran newspaper, reported in 1984 that a man who tore off the ear of a man in a brawl in Iran had his own ear amputated under *qisas* (retribution) provisions.

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38 *Globe and Mail* [Toronto], 16 October 1986.

39 *Iran: Amnesty International Briefing,* London: AI Publications, 1987,; *Iran: Written statement to the 46th session of the United Nations Commission on Human Rights*, AI Index: MDE 13/02/90, January 1990. According to an interview in November 1984 with the Head of the Judicial Police - the agency responsible for carrying out the punishment of amputation - a "device which very speedily severs the hand of a thief" had already been prepared. "To facilitate the enactment of Islamic law on severance of thieves' hands, help has been sought from relevant competent authorities, such as the Coroner's Office, the Ministry of Health, and the Medical Faculties of Tehran and Beheshti Universities". The machine was reportedly installed in Qasr Prison in February 1985. *Iran: Violations of Human Rights.* London: AI Publications, 1987, p.47.

A doctor was reportedly present though it was not clear what his role was[40].

Some role for medical personnel in amputations in Saudi Arabia is suggested by the fact that Sudan sent a delegation to that country before introducing amputations itself in order to learn about the procedures involved. The Sudanese delegation included a surgeon[41]. Direct evidence of such participation in Saudi Arabia has not yet been obtained by AI[42] though the punishment is probably carried out in the presence of a doctor with an ambulance standing by.

While amputation for theft has been an element of the law in Pakistan since the introduction of Islamic law in 1977, the medical profession there appears to have successfully resisted its practical implementation.

Advising on, or supervising, diet restriction

Punitive restriction of diet would be taken up by AI if prolonged and of such a nature as to threaten the health of a prisoner, or if it was linked with other elements of cruel treatment. AI does not have specific evidence of medical involvement though, at least in the past, laws regulating such a punishment specified that a doctor must evaluate the prisoner before the punishment is inflicted.

Certification of fitness for, and monitoring of, whippings

This is another punishment where, traditionally, medical supervision has been required in law. For example, in Pakistan, the Execution of Punishment of Whipping Ordinance, 1979, specifies that whipping should be carried out only in the presence of an authorized medical officer and in a public place. A thorough examination of the prisoner is first carried out by a doctor "so as to ensure that the execution of the punishment will not cause the death of the convict". The doctor also must indicate when an ill prisoner is fit enough to undergo the punishment[43]. Branches and members of the Pakistan Medical Association have

40 Reuters news agency report, 14 January 1984.

41 Amnesty International. *Amputation: Sudan.* AI Index: AFR 54/21/83, 23 November 1983. Another piece of evidence suggestive of a medical role (at least after the punishment) was the recent debate reported to have taken place in the Islamic *Fiqh* (Jurisprudence) Academy in Jeddah where the question of the legitimacy of medical involvement in re-attachment of severed limbs was debated. It was decided that it was contrary to the *Qur'an* for a doctor to re-attach a limb which had been severed in conformity with *Shari'a*. *Arab News*, 22 March 1990.

42 A recent press report stated that amputations in Saudi Arabia are carried out by doctors in hospitals. This has not been confirmed from independent sources however. (See Fisk R. Day that shook the House of Saud. *Independent* [London], 11 July 1990.)

43 Amnesty International. *Whipping in Pakistan.* AI Index: ASA 33/01/90, 23 February 1990.

periodically voiced opposition to these roles being required of doctors[44].

Similarly, in Jordan[45], Malaysia[46] and South Africa[47], doctors are required to examine prisoners to certify them fit for punishment and to be present at the whipping. In South Africa between 1986 and 1988 some 75,000 sentences of whipping were handed out by courts. In Mozambique, the sentence of whipping - a colonial punishment which was re-introduced in 1983 - was abolished in 1989[48].

Abuse of psychiatry for political purposes

Amnesty International's concerns in the field of psychiatry have been set out in a short 1983 document[49]. The organization's focus is strictly limited to instances where, for political reasons, psychiatric committal is used as a substitute for judicial process or where psychiatric knowledge is used to deliberately harm prisoners.

Falsely certifying someone as requiring compulsory hospitalisation, for political reasons

During the 1980s, AI received allegations of political use of psychiatry in Czechoslovakia[50], Romania[51], Yugoslavia[52] and the USSR[53], though only in the last country was it a systematic

44 For example, the Karachi Branch of the Pakistan Medical Association passed a resolution on 8 September 1983 which concluded: "We call upon the Government not to involve the medical profession in the process of flogging and to stop such punishment on humanitarian and medical grounds".

45 *Jordan: Human Rights Protection After the State of Emergency.* London: AI Publications, 1990.

46 Amnesty International. *Whipping: Malaysia.* AI Index: ASA 28/01/90, 24 January 1990. The obligations of physicians are set out in the Malaysian Criminal Procedures Code, at 290 (i)-(iii).

47 Amnesty International. *Whippings: South Africa.* AI Index: AFR 53/19/90, 26 March 1990.

48 Amnesty International. *Mozambique: Floggings.* AI Index: AFR 41/03/83, 27 May 1983. From 1985 sentences of whipping declined, though there were reports of unauthorized whippings taking place. In January 1988, an official was tried and sentenced to four years' imprisonment for ordering the unlawful flogging of a prisoner who died later as a direct result. See Amnesty International. *Mozambique. The human rights record 1975-1989: Recent government measures.* AI Index: AFR 41/01/89, September 1989.

49 See *The abuse of human rights and the psychiatric profession.* AI Index: POL 03/01/83, May 1983.

50 Amnesty International. *Augustin Navratil - Czechoslovakia:* EERAN no.31/88, 14 July 1988.

51 Amnesty International. *The political abuse of psychiatry in Romania.* AI Index: EUR 39/20/80, 11 November 1980.

and widely-used procedure. The Soviet authorities systematically substituted psychiatric assessments for legal process, turning certain political activities into signs of severe and dangerous mental abnormality. However, as the Soviet psychiatrist Dr Alexander Voloshanovich pointed out, it would be a mistake to see the issue as hinging on whether those detained were or were not in perfect mental health:

"Among [alleged victims of psychiatric abuse] whom I examined, I found a few cases where I was convinced of, or suspected, mental illness. There were individuals with apparent personality disorders or personality developments. There were people suffering psychological problems and there were sane people too. What was common in all these cases was that, *without exception*, there was no legal or medical reason for the patient to be confined in a psychiatric hospital."[54]

Recent changes in Eastern Europe, and in the USSR[55], give cause to hope that such abuses will progressively disappear.

Administering psychoactive drugs to prisoners in the absence of medical indications

Powerful neuroleptics have in the past been regularly administered to prisoners in Soviet psychiatric institutions, frequently without accompanying medication to control Parkinsonian symptoms. In Uruguay up until the mid-1980s similar allegations were made concerning political prisoners held in Libertad prison[56]. In neither case did medical indications seem to be the determining factor in the administration of the drugs.

Violence against political prisoners in psychiatric institutions

In addition to the two forms of abuse described above there is also the failure of medical personnel to protect patients from arbitrary violence inflicted by "nurses" or guards. In some

52 *Yugoslavia: Prisoners of Conscience.* London: AI Publications, 1982.

53 See, for example, the AI papers *Political abuse of psychiatry in the USSR.* AI Index: EUR 46/01/83, March 1983; and *USSR: Review of punitive psychiatry since January 1987.* AI Index: EUR 46/12/88, April 1988.

54 Voloshanovich A. *Medicine and Human Rights* (Bulletin of the British Medical Group of Amnesty International), February 1982.

55 Amnesty International. *USSR: Human rights in a time of change.* AI Index: EUR 46/22/89, October 1989.

56 Amnesty International. *Mental health aspects of political imprisonment in Uruguay.* AI Index: AMR 52/18/83, June 1983.

cases doctors or psychiatrists are reported to have encouraged such violence[57].

Death penalty

Amnesty International is unconditionally opposed to the death penalty as the ultimate cruel, inhuman and degrading punishment and violation of the fundamental human right to life. The penalty fails to offer a proven unique deterrent, it cannot be rectified in the event of a judicial error and it risks escalating the climate of violence in society. AI believes that health professionals can play an important role in opposing the death penalty, firstly by ensuring that medical ethical standards forbid, and are seen to forbid, medical participation in executions and, secondly, by arguing against the essential inhumanity of the death penalty[58]. The following activities are particularly prone to medical involvement.

Giving "expert" testimony in capital cases

In normal circumstances, providing expert testimony to a court is totally unexceptionable. All states in the USA, for example, permit introduction of medical and psychiatric evidence into criminal proceedings. However, a US Supreme Court interpretation of the constitutionality of certain expert testimony currently allows for the presentation of scientifically specious evidence.

In common with other states, Texas provides for separation of the hearings for determination of guilt and the sentencing phase in capital cases. In the latter, a jury must be satisfied that, among other things, the convicted prisoner was likely to commit "criminal acts of violence that would constitute a continuing threat to society"[59].

At least two psychiatrists in Texas regularly provide such evidence for the prosecution, in many cases without having examined the defendant[60], even though the American Psychiatric Association has submitted to the US Supreme Court that psychiatrists have no special expertise in making assessments of "future dangerousness". A dramatic case calling into question psychiatric expertise in making such judgements was that of a former death row

57 *Political abuse of psychiatry in the USSR.* AI Index: EUR 49/01/83, *op. cit.*; and *USSR: Review of punitive psychiatry since January 1987.* AI Index: EUR 46/12/88, *op. cit.*

58 For a review of the subject see: Amnesty International. *Health professionals and the death penalty.* AI Index: ACT 51/03/89, January 1989. For AI's analysis of the death penalty as a worldwide phenomenon, see *When the State Kills...* London: AI Publications, 1989.

59 Amnesty International. *The death penalty in the United States of America: an issue for health professionals.* AI Index: AMR 51/40/86, 1986.

60 In such cases, the psychiatrists are asked to make judgments about a hypothetical person sharing the characteristics of the defendant. For a critical discussion of this procedure see Appelbaum PS. Hypotheticals, psychiatric testimony and the death sentence. *Bulletin of the American Academy of Psychiatry and the Law*, 1984, **12**:169-77.

inmate and, according to observers, probably innocent man[61] who was convicted of the murder of a police officer in the 1970s; according to a psychiatrist at his trial, he constituted "a continuing threat to society" and this evidence contributed to a death sentence which was later commuted on appeal. His sentence was subsequently quashed and the prisoner released though without the state officially finding him innocent. Whether he is a "continuing threat to society" remains to be seen.

Certification of competence or fitness for execution

The US Supreme Court ruled in 1989 that executing juveniles and mentally retarded prisoners was not an inherently cruel or unusual punishment. However, legal practice has shown that mental retardation and mental illness can constitute lack of competence for execution. It is likely, therefore, that evidence will be presented by both defence and prosecution on this issue with the latter introducing medical, psychiatric or psychological testimony which, if persuasive to the jury, may contribute ultimately to the execution of the prisoner[62].

Similarly, when a prisoner appears to have become mentally disturbed after sentence has been pronounced, the state may call upon mental health professionals to counter defence

61 Randall Dale Adams was released, but not pardoned, in 1989 after the production of a film, *The Thin Blue Line* (1988; director: Errol Morris). The film was originally intended to focus on the psychiatrist, Dr James Grigson, but the theme of the film radically changed after Morris became convinced of the innocence of Adams whom he met by chance during filming.

62 See *The death penalty in the United States of America: an issue for health professionals.* AI Index: AMR 51/40/86, *op. cit.*. Critics of the death penalty can adopt different positions on psychiatric testimony in capital cases. Paul Appelbaum has recently argued, for example, that a forensic psychiatrist can legitimately give testimony on competency to be executed even if this could lead to the prisoner's execution since forensic psychiatric ethics are not framed by the clinical psychiatrist's principles of beneficence and non-maleficence. See Appelbaum P. The parable of the forensic psychiatrist: ethics and the problem of doing harm. *International Journal of Law and Psychiatry*, to be published 1990. For a contrary view see Wallace DH. Incompetency for execution: the Supreme Court challenges the ethical standards of the mental health professions. *Journal of Legal Medicine*, 1987, **8**:265-81; Ewing CP. Diagnosing and treating "insanity" on death row: legal and ethical perspectives. *Behavioral Sciences and the Law*, 1987, **5**:175-85. Ewing states, for example, "In some instances, psychologists and psychiatrists may conclude that the condemned inmate is insane and thus spare him or her from execution, at least temporarily. In other instances, however, they will conclude that the condemned inmate is 'sane' and thus participate in a process which paves the way for the inmate's death. If they do their jobs honestly and objectively, [they] have no way of telling in advance what, if any, conclusions they will reach." (p.182.) For an abolitionist argument in favour of psychiatric evaluations of competence see Radelet ML and Barnard GW. Ethics and the psychiatric determination of competency to be executed. *Bulletin of the American Academy of Psychiatry and Law*, 1986, **14**:37-53.

appeals for a commutation on grounds of insanity, again with the possibility that, if accepted by the court, their testimony could lead directly to the prisoner's execution[63].

Providing mental health care in order to allow execution to take place

A corollary of the above is that when a prisoner has been found incompetent to undergo execution, he or she may be required to undergo medical or psychiatric treatment in order to be rendered fit for execution[64]. In the one such documented case, that of Gary Alvord in Florida, the prisoner was sent to a mental hospital where some staff members refused to treat him, and others did so only after much debate and with great ambivalence. Eventually he was assessed by three state psychiatrists and found competent to return to death row.

Assistance at an execution

There has been a long tradition of medical attendance at executions in Europe and North America. Since the introduction of lethal injection in the USA as a "humane" form of execution, there has been a growing debate in the medical profession about the ethics of the increasing medicalisation of the death penalty. While initially the fear related specifically to direct medical involvement in administering the injection itself[65], the debate has widened.

From the reports received by AI, it is clear that the presence of a doctor in the execution chamber always risks their active participation in the execution process even where the method is not at all "medical". For example, several executions in the US have been characterized by a failure to definitively kill the condemned at the first attempt and the doctors attending the execution have advised the executioner of the need to continue or renew the execution procedure[66]. As a recent paper in the weekly British medical journal,

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63 Such a role has not been ruled unethical by US or international medical bodies. However, it is clear that medical personnel testifying in such a way as to increase the possibility of the prisoner's death must address serious ethical dilemmas uniquely posed by the death penalty.

64 Both Appelbaum, and Radelet and Barnard, see this role as totally inimical to the role of the psychiatrist or other health professional. See Appelbaum P. op. cit., Radelet ML, Barnard GW. Treating those found incompetent for execution: ethical chaos with only one solution. *Bulletin of the American Academy of Psychiatry and Law*, 1988, **16**:297-308.

65 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. The fear of medical involvement in execution by lethal injection appears to remain a real one: a recent report suggested that three Illinois physicians were asked by prison authorities to assist in such an execution. See *Medical concern: the execution of Charles Walker, United States of America.* AI Index: 51/38/90, 21 September 1990.

66 Some examples are given in *The death penalty in the United States of America: an issue for health professionals.* AI Index: AMR 51/40/86, *op. cit.*. Sometimes the failure to kill efficiently has disturbing consequences for witnesses. In the recent execution of Jesse Tafero in Florida on 4 May 1990, the sponge cap placed on the head of the condemned man burst in

The Lancet, recalls, the very first judicial electrocution in 1890 was one such execution [67].

"Harvesting" of organs or body fluids prior to or after execution

The use of the organs of the executed prisoner has been seriously suggested by a US doctor, Jack Kevorkian, on the grounds that it would give meaning to the death of the condemned. He has also asserted that it is an ethical obligation of the doctor to participate in lethal injections[68]. To AI's knowledge his arguments have not been seriously entertained by legislators or the medical profession in the US. In 1985 however, Florida state officials acknowledged that the brains of executed prisoners had been given without authorization to a neurobiologist for medical studies[69]. The practice was halted after public outcry.

In Taiwan, however, in July 1989, the daily newspaper, *The China Post*, reported that some Taiwanese hospital doctors were urging that executions take place in such a manner as to allow the use of the heart of the executed prisoner for transplantation. The World Medical Association sought the views of the Chinese [Taiwanese] Medical Association which replied that it is "in general not in favor of this proposal"[70]. A subsequent report in the *China Post* (17 April 1990) again quoted a doctor from the National Taiwan University Hospital arguing for execution by shooting in the head with immediate transfer of the body to a life support system until the body organs can be harvested. The *China Post* of 16 August 1990 reported that the Justice Ministry approved a change in execution method to preserve the executed prisoner's heart for transplant provided that the prisoner, and their spouse and family have given written permission[71]. It was decided that prisoners refusing permission for the use of their heart will continue to be shot in the heart from behind.

Amnesty International received reports in 1984 that condemned prisoners in Iraq were being ex-sanguinated before execution to provide blood for field hospitals in the Iran-Iraq war zone[72].

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flames when the first charge was administered. Witnesses described the scene as "violent" and "gruesome". A journalist stated that the malfunction "changed the reported sterility of the electric chair into a scene that more than bordered on the grotesque". See *AI Urgent Action* AMR 51/19/90, 10 May 1990.

67 See Jones GRN. Judicial electrocution and the prison doctor. *Lancet*, 1990, **335**:713-4.

68 See Kevorkian J. Medicine, ethics and execution by lethal injection. *Medicine and Law*, 1985, **4**:307-13.

69 *International Herald Tribune*, 10 October 1985.

70 Letter from WMA to AI, 6 December 1989.

71 It was decided by the Justice Ministry that doctors would determine brain death after the coroner had certified death and at the hospital prior to transplantation surgery.

72 Amnesty International. *Torture in Iraq - 1982-1984*. AI Index: MDE 14/02/85, April 1985.

Inadequate health care

The deliberate withholding of care

Amnesty International is concerned when inadequate medical care appears to be the result of deliberate politically-motivated policy amounting to cruel, inhuman or degrading treatment or where the lives of prisoners are negligently put at risk[73].

Some caution has to be exercised in attributing blame to medical staff in cases of medical neglect. In many cases, it is by decision of the prison authorities that individual prisoners do not receive treatment which prison doctors have recommended. In such cases the question of the appropriate response by prison medical staff is a crucial one. In other cases there may be genuine difficulties in providing necessary medical treatment. In some cases however, the problem seems to lie with the medical staff. For example, a prisoner held in Kars prison in Turkey alleged that in 1984 he developed sores on his feet which the prison doctor responded to unsympathetically. When these sores worsened, he was prescribed a salve and though he eventually could not walk unaided he was not recommended for a hospital visit. After complaining about the doctor's behaviour, the prisoner was confronted by the doctor who ordered guards to beat him. When he was eventually transferred to hospital he had developed gangrene and had, first his toes and later his foot, amputated[74].

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73 In such cases it could be regarded as cruel, inhuman or degrading treatment or punishment. See for example, *Mauritania, 1986-1988: Background to a crisis.* AI Index: AFR 38/13/89, November 1989. Four deaths were reported at Oualata prison in August and September 1988 including that of a former Minister of Health. Deaths appeared to be linked to malnutrition. Even more dramatic were reports from Cameroon that as many as four or five prisoners were dying each day during certain periods in 1987 and 1988. It was reported to AI that, in December 1987, 44 prisoners died, 42 of them from malnutrition. Medical care was said to be grossly inadequate. See *Cameroon: harsh prison conditions for criminal and political prisoners,* AI Index: AFR 17/03/89, 30 May 1989. See also *Cameroon: deaths from torture at Nkondengui Prison*, AI Index: AFR 17/04/90, 15 March 1990. A high rate of deaths in Nigerian prisons from malnutrition and disease was reported in *Nigeria: the death penalty*, AFR 44/02/89, 6 February 1989, and in *Nigeria: public executions in Anambra State and armed robbery suspects die in detention in Oyo State*, AFR 44/09/90, 2 May 1990. In a recent case in Romania, AI expressed its concern at the unacceptably high death rate in psychiatric orphanages where young children died of starvation and cold as a result of severe neglect amounting to cruel, inhuman and degrading treatment.

74 *Turkey: torture and medical neglect of prisoners.* AI Index: EUR 44/28/88, *op. cit.* See also *Turkey: torture and unfair trial of political prisoners.* AI Index: EUR 44/101/89, *op. cit.* In response to the latter document, the Turkish Embassy in London sent AI a letter with numerous medical reports attached. These concluded that "medical reports certify that the

In some cases, doctors have placed the interests of the security forces above those of the prisoner. For example, the black South African Marcus Thabo Motaung, was arrested on 1 March 1982 for treason and other alleged offences. During his arrest he was shot in the hip and groin. The District Surgeon who attended him in security police custody was reported to have said later that she thought it more important for him to assist the police with their enquiries than to receive treatment, which was refused for two days[75].

Deliberate mis-prescribing of drugs or prescribing without examination

A Turkish prisoner described the medical care in Metris prison in these terms:

"...it was generally like this: you asked for the doctor during the morning count or you could write down your name on a list for those who wanted medication. With the exception of vitamins, you were entitled to ask for any kind of medicine...If you had asked for the doctor he would come, open the door's observation hatch and speaking through this he would ask about your complaints -there was no way of getting examined."[76]

Another testified that:

"When we went to the infirmary, there was no examination at all; by looking into our faces we were given aspirin, novalgine, panalgine and similar drugs."[77]

Role in hunger-strikes

Medical involvement in forcible feeding

Amnesty International is aware of the position of the World Medical Association as outlined

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detainees were not tortured or ill-treated during police custody". AI rejected this assertion on the basis of evidence that most medical examinations carried out on prisoners are cursory, sometimes carried out on a group of prisoners and are limited at best to noting *visible* traces of physical abuse. In February 1989 the Presidents of the Bar, Medical and Pharmacists' Associations of Ankara wrote an open letter to the Turkish Prime Minister stating, *inter alia*, that "the current practice of having detainees medically examined and reports on their behalf issued by physicians working in official state institutions, who are open to direct or indirect pressure, creates various suspicions... We think that our proposals [for examinations to be carried out by an independent panel of doctors] will be an important step towards preventing torture". See Amnesty International. *Turkey: continuing violations of human rights.* EUR 44/66/90, May 1990.

75 Amnesty International. *The case of Marcus Thabo Motaung: South Africa.* AI Index: AFR 53/41/82, 23 August 1982. Marcus Motaung and two co-defendants were hanged on 9 June 1983 - the first executions for treason in South Africa for 70 years.

76 *Turkey: continuing violations of human rights.* EUR 44/66/90, *op. cit.*

77 *Turkey: continuing violations of human rights, op. cit.*

in the Declaration of Tokyo[78] but does not take a position itself against forcible feeding unless it is carried out in a deliberately cruel and degrading manner. Thus in the examples below, AI took action in the first case but not in the second.

In Morocco, three political prisoners maintained a hunger-strike from mid-1985 for more than four years, during which time they were forcibly-fed, kept bound to their beds in unsanitary conditions, and received medical care from guards, reportedly on the advice of doctors who were not permitted to see the prisoners. Since the second month of their hunger-strike they were kept isolated in a hospital, ending up held in basement "cells" in Averroes Hospital, Casablanca; they were not permitted any visits by family members. A second group of hunger-strikers were also forcibly fed in Avicennes Hospital, Rabat; one of their number died in August 1989[79].

A recent hunger-strike by militant political prisoners in Spain led to forcible feeding by some medical staff attending them in prison. One of the doctors reportedly involved in the forced feeding was fatally shot on 27 March 1990. Press reports suggested that the shooting was carried out by members of the political group to which the striking prisoners belong[80]. A recent press article reported that the Spanish Constitutional Tribunal has ruled that the authorities are justified in force-feeding prisoners who are on hunger-strike[81].

Conclusion

The evidence available to AI must be regarded as far from complete. Frequently AI only learns of abuses indirectly, sometimes when medical associations protest. Nevertheless, what evidence there is suggests that some doctors facilitate human rights violations by direct participation; others, while not directly active, nevertheless know of the violations and willingly acquiesce in their infliction; still others can be regarded as unwilling observers of abuses - unwilling to participate but unaware of what action to take.

With regard to corporal punishments, it is more likely that those carrying out, or assisting in carrying out the punishment, are supporters of a medical role. A strong stand by the international community against medical involvement may not dissuade each of them but

78 This states (in part) at paragraph 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....". For the complete text see *Ethical Codes and Declarations Relevant to the Health Professions, op. cit.*

79 Amnesty International. *Medical concern: Prolonged hunger strike, Morocco.* AI Index: MDE 29/07/89, 14 September 1989; Raat A-M. Hungerstrikes in Morocco. *Lancet,* 1989, **ii**:982-3; *AI Urgent Action: Morocco,* AI Index: MDE 29/15/90, 11 May 1990. At the time of writing, two prisoners remain on hunger-strike while held incommunicado in Averroes Hospital. Those in Rabat ended their hunger-strike in February 1990.

80 *Le Monde,* 29 March 1990.

81 *Times* [London], 4 July 1990.

may contribute to a change in the perception of the acceptability of these punishments.

In seeking a strategy to combat such involvement it is instructive to examine examples where doctors have taken a stand, to look at the outcome and to determine the factors which might encourage the medical profession to be more outspoken in opposition to human rights violations. In the cases of corporal punishment cited above (see pp. 15 above) it is clear that the Mauritanian and Pakistani associations were *a priori* opposed to punishments such as amputation and flogging. This did not necessarily stop the punishments outright but contributed to the struggle to end them. It is certainly clear that individual doctors had a less onerous task in making their own decision when the association took a unified stand on the issue.

With regard to torture, the picture is mixed. In Chile, the medical association has actively campaigned against torture and medical involvement since gaining control over its own affairs in 1982 after years of military control[82] though opposition of the association did not, in itself, end medical involvement. In Uruguay, only one health professional was identified by Bloche[83] as actively opposing ethical violations from within the military health corps. He was held incommunicado for one week for his refusal "to supply information about his conversations with incarcerated elements". The two main Uruguayan medical associations were able, in the final year of the military government, to vigorously pursue the promotion of medical ethics and an investigation of medical abuses against prisoners, something they have continued to do since[84].

In South Africa, the case of Dr Wendy Orr received widespread publicity in 1985. She has been, to AI's knowledge, the only South African district surgeon to have initiated a court action to restrain police from committing abuses against prisoners in their care. She had previously reported the abuses she had seen to her superior medical officers without seeing any action on their part. In general the majority of district surgeons appear to have remained silent in the face of widespread abuses against prisoners[85]. Dr Orr was

82 See note **Error! Bookmark not defined.** above. Prior to, and just after, the coup in September 1973 the position of the association was highly polarized with some of the leadership opposed to voicing opposition to human rights abuses - even those directed against doctors. See Hamilton G. Professionalism - lessons from Chile. *Medicine and Society*, 1981, **7**:14-17 and **7**:30-33.

83 Bloche. *Uruguay's Military Physicians. op. cit.*

84 See, for example, Martirena G. The medical profession and problems arising from the implication of physicians in acts of torture in Uruguay. *Danish Medical Bulletin*, 1987, **34**:194-6.

85 The failure of district surgeons to report instances of ill-treatment to the Medical Association of South Africa after MASA has asked for such evidence to be reported was confirmed to Amnesty International at a meeting of the World Medical Association in Madrid in 1987. At that time, the absence of reports of ill-treatment was apparently interpreted by MASA as indicating that ill-treatment did not occur or was grossly exaggerated. For discussion of the Orr case see Rayner M. *Turning a Blind Eye?, op. cit.* Those detainees who

subsequently soon transferred to other duties.

In the Republic of Korea, one doctor who publicly exposed a fatal episode of torture - unintentionally, according to his testimony[86] - had a major impact on political reforms in that country but also paid a serious price. Dr Kwang Chok chun, a pathologist with the National Institute of Scientific Investigation, was called to examine the body of a 21-year-old student, Park Chong-chol, after he had died in detention. The police pressured Dr Kwang to state that Park had died of "shock". However, he saw immediately that Park had swallowed large amounts of water and had died as a result of having his throat crushed against a hard object, possibly the rim of a bath tub, and he recounted the probable true course of events to a journalist friend who promptly published the results. Together with the public statements of a second doctor, this created extremely negative publicity for the authorities and public pressure for investigation of the death.

When 12 months later Dr Kwang published a diary of the events, pressure to investigate the death fully became an issue again and led to criminal charges against other police officers. For Dr Kwang however, his career in pathology came to an abrupt halt shortly after the student's death and the subsequent leaking of his conclusions. He felt forced to resign, explaining to a US journalist:

"I would not have been able to work any longer in that place....The people I dealt with every day were the police. They were creating an impossible atmosphere....I used to lecture at the police academy. And the atmosphere there was hostile as well. I was getting threatening phone calls at home, and had to change my phone number. I just couldn't go on after that."[87]

The need to address the dilemma of the doctor (or any other health worker) having to confront situations of serious abuse was succinctly summed up at a seminar convened by the Council of Europe in 1982 to discuss the doctor and human rights:

"The intolerable choice between complicity and heroism - between the side of the torturers and that of the victims - should not be left to the individual conscience. It is incumbent on all of us, on each national and supranational community, to elaborate rules and conventions, but above all, *concrete* rules, which not only prohibit participation in torture but effectively protect the doctor against the risks to which refusal to assist

were protected by Dr Orr's court action were recently awarded damages, five years after the initial action. *The Star* [Johannesburg], 4 July 1990.

86 A year after giving a journalist what he mistakenly thought was an 'off-the-record' account of a death under torture, Dr Kwang Chok chun said: "I didn't think it would turn out like this. I'm not interested in being a hero. Frankly, I think I may be a fool." *New York Times*, 4 May 1988.

87 *New York Times*, 4 May 1988.

torture will expose him or her."[88]

Of course rules must be elaborated but the strongest rules are only as valuable as the will to observe and, where necessary, police them. While the ethical standards for the individual are, by and large, clear, the obligations on professional associations to support threatened individuals, to investigate and discipline those found guilty of assistance in torture, and to wage a war against medical involvement in human rights violations are less clear. In a discussion of the role of medical ethics in the protection of prisoners (particularly the United Nations' Principles of Medical Ethics and the World Medical Association's Declaration of Tokyo), Nigel Rodley noted that "...the UN Principles are silent on what should happen if a health worker fails to comply with the Principles". Likewise, "the Declaration of Tokyo does not deal with the question at all, and neither instrument gives explicit guidance as to the responsibility of colleagues when confronted by a breach of ethics by fellow health personnel"[89]. In other words, the prohibition on torture is strongly stated but the obligations on associations and individuals to take action to combat the abuses of particular members of the profession are not.

In addition to standards, there is a need for a method of analyzing human rights situations as they relate to the health professions' role in protecting the citizen. In January 1989 in Paris a conference on "Medicine at Risk" was organized by the French Section of Amnesty International[90]. One of the working parties at the conference set out some of the indicators which should stimulate concern on the part of professional associations and others that there is risk of human rights violations with the progressive involvement of health professionals. For example, it was suggested that any failure by the authorities to guarantee prisoners the same rights to health care as other citizens should alert health professionals to the risk of the erosion of human rights[91].

Abuses such as those documented in this report suggest the need for a serious review of the ways in which the organized health professions can act singly and in concert with other non-governmental organisations to bring about an end to medical involvement in human rights violations, and to support individuals and national organizations which are actively opposing such involvement. In addition, those individuals found to be colluding in torture and other abuses should be disciplined, both professionally and legally. Two-and-a-half thousand years after Hippocrates, it is surely time that *all* medical practitioners observe the dictum "above all, do no harm".

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88 Lore C, di Georgi S, Pogliano C. La torture. In: Proceedings of a Council of Europe Colloquium, *Le médecin et les droits de l'homme*. Santa Margherita Ligure [Italy], 27-28 March 1982. Strasbourg: Council of Europe, 1985. p.155.

89 Rodley N. *The Treatment of Prisoners Under International Law*. Oxford: OUP, 1987, pp.298-9.

90 *Médecine à risques: servir ou subir la répression*, UNESCO, Paris, 19-21 January 1989.

91 See *Médecins resistants, médecins tortionnaires, op cit*, Report of Working Party 3.

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