Prescription for Change

Health professionals and the exposure of human rights violations

Prescription for change:
Health professionals and the exposure of human rights violations

1. Introduction

> [The police] wanted a report from the State Hospital saying that no beating or pressure had been applied. I couldn't say "Undress, I'm going to examine you", since that would be interpreted as me taking sides against them. Anyway, I started, carried out an examination, and the man had apparently been hung up. I confirmed this, sat down, gave my report, and it was immediately torn up. I experienced these things. They ask: "What are you writing, doctor?" They ask: "Have you made a report listing injuries?" If so, they can go elsewhere to get the sort of report they want.[1]

Health professionals working in situations of widespread human rights abuses and conflict can experience immense problems and face significant personal risks in carrying out their professional duties. Apart from the risks they share will other citizens in times of heightened tension, conflict or political repression, they face specific problems. As carers, they come into contact with a wide spectrum of the population, including those who themselves are at risk of human rights violations. As generally well-known members of their communities, they can become the target of forces intent on making examples of community leaders. Some can become the focus of interest because of their political activities and their role in health promotion and protection may be incidental.

Repressive governments and armies sometimes appear to regard the consolidation and expansion of public health services as inherently subversive or as a vulnerable target in a conflict and this places health personnel at risk. In Central America in the early 1980s there were numerous cases of health personnel being targeted because of their professional activities; the attacks appeared to be based on the belief that health personnel were "treating the enemy", but some attacks appeared to lack even this rationale[2].

This report focuses on the role of the health professional as witness and exposer of torture and other human rights violations. Health personnel are well-placed to observe human rights violations because they can meet victims in the course of their professional work. Their role as health monitors makes it likely that abuses will come to their attention, and in some cases they encounter abuses face-to-face. The next step—to try to stop the abuses or to denounce them—has risks. In some cases doctors, nurses or other health workers can pay a high price for adhering to their principles. As this report will show, health workers have been imprisoned, killed or silenced in other ways because of their refusal to condone human rights violations. In other cases, health professionals have been able to take action to prevent or to expose abuses while at the same time avoiding any damaging consequences. However, in many cases the pressure brought to bear on individual doctors or nurses has been intense to the point of being overwhelming (though there is evidence that a minority of health professionals appear to have collaborated voluntarily in human rights violations).

In Iraq in 1994, doctors were required by law to amputate the ears and brand the foreheads of

---

[1] *Southeast Turkey: The health professions in the Emergency Zone.* AI Index: 44/146/94, December 1994, p.7.

[2] *El Salvador: Further reports of violations of medical and health care rights*. AI Index: AMR 29/19/81, March 1981; *Medical staff victims of "death squads" in Guatemala*. AI Index: AMR 34/08/82, February 1982.

military and civilian "deserters"; they were told that if they refused the same fate would happen to them. In spite of the heavy pressure brought to bear on Iraqi doctors to comply with government decrees, and in the absence of organized political support, doctors did resist. However, they paid a price. One doctor was reportedly executed and many were imprisoned for their refusal to exercise medicine punitively[3]. The effect of this additional pressure on doctors has been to compound the difficulties within the health sector in Iraq and contribute to the drain of health professionals from that country. This example underlines the vulnerability of the individual health practitioner in the absence of a strong collective refusal to compromise ethical and professional standards.

Finally, some health professionals assist governments in the perpetration of human rights violations, either passively through their failure to challenge unacceptable practices, through giving professional advice or other assistance or through active participation in abuses by, for example, monitoring a torture victim's capacity to withstand more torture or "patching up" the victim for appearance before a court[4].

Figure **0**. Iraqi television picture of a branding victim. Iraqi doctors were required to carry out this punishment. Many refused and were themselves punished.

The role of the health professional in situations where human rights are violated is an important one. By putting their patients and communities first and reporting accurately and honestly on what they see, they can make a major contribution to the defence of human rights and the rule of law. This report documents the health professional's ethical obligations concerning their role in protecting human rights, the ways in which they can contribute to more effective protection of the population, the specific skills they can bring to the documentation of human rights violations and the ways in which they fail to fulfil this role—through deliberate connivance with human rights violators, through ignorance, or because of coercive pressures upon them—and the changes necessary to improve their effectiveness as guardians of basic rights.

What are the links between medical ethics and human rights?

Human rights are those inalienable rights which transcend political boundaries, ideologies and religious faiths. The Universal Declaration of Human Rights adopted by the United Nations in 1948 embodied rights relating to personal liberty, security, family and faith[5]. Professional ethics on the other hand is a codified guide regulating the behaviour of medical and other health professionals in their dealings with patients and with each other. Both have at their heart certain understandings of the value of the human

[3] *Amputations and branding; Detention of health professionals*. AI Index: MDE 14/13/94, October 1994. Further unpublished data held by Amnesty International.

[4] *Involvement of medical personnel in abuses against detainees and prisoners: revised and updated.* AI Index: ACT 75/08/90; British Medical Association. *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses.* London: Zed Books, 1992; *Psychiatry: a human rights perspective*. AI Index: ACT 75/03/95, 1995.

[5] UN. Universal Declaration of Human Rights, adopted 10 December 1948. See: *Human Rights: A Compilation of International Instruments*, Volume 1 (First Part). New York and Geneva: United Nations, 1994; pp.1-7.

individual and of his or her right to be treated with dignity and respect. Amnesty International believes that the ethics of the health professions should reinforce human rights and make health professionals allies in its campaign for the promotion and protection of basic rights. As part of it human rights promotion activities, Amnesty International has published and disseminated codes of professional ethics with a view to increasing awareness of basic ethics and the links these have with the promotion and protection of human rights[6].

It was as a result of this link, as well as through the engagement of committed medical professionals, that medical groups developed within AI in the mid-1970s. In the more than two decades of their active involvement in Amnesty International, health professionals have campaigned against human rights violations and against the involvement of health professionals in such violations. They have also sought to protect colleagues under threat for their professional or human rights activities. In all these activities the basic tenets of medical ethics and human rights have been an important guide.

Amnesty International's concerns

This report is prompted by the persistent failure of governments to effectively utilize the skills of health professionals in the documentation of human rights violations and by the need to promote improved standards in human rights documentation. Amnesty International is also aware that some health professionals are themselves assisting in the covering up of torture, political killings and other abuses: consciously by deliberate failure to record and effectively document signs of abuse; reluctantly because in spite of their own values they cannot resist the pressure brought to bear on them by police or security agents; or unconsciously because they do not have the training or skills to recognize and expose abuses in an adequate manner.

On the other side of the coin, health professionals are under attack for their professional and human rights activities where they come into conflict with the aims of governments. Governments apply different types of pressure and medical evidence is treated in different ways in different parts of the world. Some doctors come under direct physical pressure to conceal evidence of human rights violations. This can be in the form of threats, harassment, arrest, prosecution and even torture and death. In some circumstances the economic pressures under which the health professions work provide a powerful tool for vested interests to ensure that doctors and other health workers feel unable to act in a way which could jeopardize their professional position. Other health professionals work in an ideological climate in which the interests of the government and those of the individual, including the health professional, militate against a stand in favour of a persecuted, alienated or rebellious minority. Finally there are those countries where medical evidence is brought to light—sometimes very persuasive and damning evidence—but where it is blocked from the courts of justice. The police either prevent its submission to a court or judges ignore the medical findings in favour of evidence introduced by police or security agents.

If health workers are to play the role which their ethics and professional responsibilities demand of them, then they must be given protection and support from the authorities and from their

[6] *Codes of Professional Ethics*, 1976, revised 1983; *Ethical codes and declarations relevant to the medical profession*, 1985 (most recently revised as *Ethical codes and declarations relevant to the health professions*, 1994.)

colleagues nationally and worldwide. It is evident that this protection is not only not being given but in many cases health professionals are made deliberate targets by governments and are without support from their colleagues and professional associations.

The report contains a number of recommendations to governments, to health professionals and to the international community which, if implemented, would go some way to rectifying the current unacceptable situation. It is time for the rhetoric of rights and ethics to be realized.

2.Medical ethics, human rights and international standards on the prohibition, investigation and exposure of torture

It is a fundamental principle of medical practice that the patient's interests should be central in the healing relationship. The long-standing guiding rule in the health professions has been that the healer should act in the interests of the patient's well-being and, in the words of the Hippocratic principle, above all never to do harm. To put this fundamental credo into the working language of the health professions, ethical codes have been articulated over the centuries by differing religious and cultural traditions. The Greek body of ethics deriving from the 5th century BC has been added to by Roman, Arabic, Jewish, Hindu and other traditions[7]. In recent years these have been refined and widely agreed by international professional bodies such as the World Medical Association and the International Council of Nurses. In addition, new perspectives on traditional ethical values have been added by those working in the field of humanitarian medicine—the International Committee of the Red Cross, Médecins sans Frontières and Médecins du Monde among others— and Amnesty International itself has provided important contributions to the prevention of human rights violations and elaboration of the role which health professionals can play in this goal[8].

Aside from the multitude of ethical principles guiding professional behaviour towards the dying, the physically and mentally ill, the handicapped, children, and professional colleagues among others, there are codes bearing on the behaviour of health professionals towards prisoners and others who have lost their freedom. The World Medical Association, for example, adopted the Declaration of Tokyo in 1975. This defines the WMA's proscription of medical involvement in torture and other cruel, inhuman or degrading treatment. In article 1 it states that:

> 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.[9]

Other ethical codes also imply an obligation on the part of the doctor to refrain from such self-evidently harmful behaviour:

[7]Castoglioni A. *A History of Medicine*. 2nd ed. New York: Knopf, 1947.

[8]See, for example, the Ten Point Program for the Prevention of Torture, the 14 Point Programs for the Prevention of Disappearances and Extrajudicial Executions, in: Amnesty International. *Ethical Codes and Declarations Relevant to the Health Professions. op cit.*

[9]WMA Declaration of Tokyo. Article 1. In: *ibid*.

I will not permit considerations of age, disease of disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing to intervene between my duty and my patient.
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.[10]

and

A physician shall ... be dedicated to providing competent medical services in full technical and moral independence, with compassion and respect for human dignity.[11]

The International Council of Nurses also proscribes a nurse's involvement in, or tolerance of, torture in these terms:

The nurse shall not countenance, condone or voluntarily participate in:
Any deliberate, systematic or wanton infliction of physical or mental suffering or any other form of cruel, inhuman or degrading procedure 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;
Any treatment which denies to any person the respect which is his/her due as a human being.[12]

The ethical perspective of the ICRC is most clearly seen in the commentary on the Protocols Additional to the 1949 Geneva Conventions[13] which will be discussed below.

Action in the face of abuses

While the WMA Declaration of Tokyo takes pains to explain the ways in which doctors should not "countenance, condone or participate in" torture, it does not say precisely what doctors should *do* when they find cases of torture or similar egregious abuses. This point will be addressed below and in chapter 5. By contrast, an ICN code—the Nurse's Role in the Care of Detainees and Prisoners—does state that:

Nurses having knowledge of physical or mental ill-treatment of detainees and prisoners must take appropriate action including reporting the matter to appropriate national and/or international bodies[14].

It is clear from the above analysis that the role, as currently defined, of both the doctor and the nurse in promoting exposure of torture as a matter of professional ethics is limited, though the foundations for such action are clearly imbedded in the codes of both.

The potential role of the health professional in protecting the rights of detainees and prisoners

[10]WMA Declaration of Geneva. *Ibid*.

[11]WMA International Code of Medical Ethics. *Ibid*.

[12]International Council of Nurses. Nurses and torture. *Ibid*.

[13]International Committee of the Red Cross. *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*. Geneva: Martin Nijhoff Publishers, 1987 [hereafter, *ICRC Commentary on Geneva Protocols*]

[14]ICN. The Nurses Role in the Care of Detainees and Prisoners, 1975. This formulation does not appear in other similar declarations subsequently adopted by the ICN.

is alluded to in a number of United Nations standards though again the question of what the individual practitioner should do when encountering abuses is not clearly spelled out. For example, while the Standard Minimum Rules for the Treatment of Prisoners specifies that a doctor should be available in all prisons to care for the medical needs of prisoners and to advise the prison administration on matters of hygiene, there is no advice on what to do when the doctor witnesses, or receives complaints of, gross ill-treatment of detainees. The United Nations Body of Principles for the Protection of All Persons under Any Form of Detention of Imprisonment contains provisions for the protection of prisoners including, at Principles 24, 25 and 26, measures relating to medical care.

> A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary (Principle 24)[15].

Moreover, such a person (or his or her counsel) shall, subject to certain practical qualifications, have the right to request "a second medical examination or opinion" (Principle 25) and the fact that any medical examination was made shall be recorded together with the name of the examining physician and the results of the examination; access to the medical records "shall be ensured" in compliance with "relevant rules of domestic law" (Principle 26). Again, there is no mention of what should be done in the event that the examining physician encounters evidence of illegal ill-treatment.

The UN Principles of Medical Ethics which, unlike the Declaration of Tokyo, are applicable to all health professionals, unambiguously condemn "participation in, complicity in, incitement to or attempts to commit torture" as a "gross violation of medical ethics"[16]. However they too fail to address the question of what action health professionals should take after they encounter torture. While it is clear that the doctor should not carry out or assist in torture, it is silent on what should be done by the same doctor who discovers it.

It is not only the living who bear marks of torture and ill-treatment which may come to the notice of health professionals. Individuals who die, whether in custody or while at liberty, can bear the signs of human rights violations. At the initiative of the Minnesota Lawyers International Human Rights Committee[17], an international group of experts in forensic science, law and human rights contributed to the elaboration of a draft set of principles on the effective prevention and investigation of extrajudicial executions. These were subsequently reviewed and adopted by the UN Economic and Social Council as resolution 1989/65 and, together with a protocol for forensic medical and anthropological investigations, were incorporated in the subsequent *Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions*[18].

---

[15]UN Body of Principles. In: *Human Rights: A Compilation of International Instruments*, Volume 1(First Part). New York and Geneva: United Nations, 1994; pp.265-74. Principle 24 also specifies that "This care and treatment shall be provided free of charge".

[16]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 or punishment, principle 2. In: *Ethical Codes and Declarations Relevant to the Health Professions: An Amnesty International Compilation of Selected Ethical Texts*. London: AI Publications, 1994, pp. 50-53. [Hereafter, "Principles of Medical Ethics"]

[17]Currently named "Minnesota Advocates for Human Rights" and based in Minneapolis/St Paul in Minnesota, USA.

[18]United Nations. *Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions.* New York: UN, 1991.

Those who drafted the Manual hoped that the Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions (contained within the Manual) would, if observed, lead to a decrease in such unlawful killings.

> First, use of the adopted procedures during death investigations should produce the evidence necessary for increased detection and disclosure of other [extrajudicial] executions. The persons responsible...can then be held accountable through judicial or political sanctions. Secondly, adoption of the standards will also provide international observers with guidelines to evaluate investigations of suspicious deaths....
> [Moreover] a Government's compliance with these standards...may increase confidence in the rule of law...[19]

The Principles set out some important protections and measures for the investigations of deaths. For example, principle 7 states that

> qualified inspectors, including medical personnel, ... or [an equivalent independent authority] shall conduct inspections in places of custody on a regular basis, and be empowered to undertake unannounced inspections on their own initiative...

Principles 9 to 17 deal with the investigation of any suspected unlawful killing. Principle 12 states that the body of a deceased person "shall not be disposed of until an adequate autopsy is conducted by a physician, who shall, if possible, be an expert in forensic pathology". In the event that exhumation of a body is required, such exhumation should be undertaken and an autopsy and examination of the skeletal remains carried out.

The principles, in sum, set out clearly both the rationale and procedures for an independent investigation which draws on appropriate medical expertise, and which requires access by investigators, family and legal counsel to the evidence, protection for investigators and witnesses, adequate time for investigations, and publication of a written report within a reasonable period of time.

Human rights violations during conflicts

The ethics of medicine in periods of armed conflict are essentially the same as those applying in times of peace, as a World Medical Association declaration affirms. The Regulations in Time of Armed Conflict go on to state that :

> 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.[20]

The Geneva Conventions of 1949 and the 1977 Protocols Additional to the Geneva Conventions of 1949 affirm the unconditional proscription of the use of torture and the requirement for medical care to conform to basic ethical principles.

Common Article 3 of the four Conventions states that in conflicts "not of an international

[19] *Ibid.*, p.14.

[20] WMA. Regulations on Time of Armed Conflict.

character" torture and similar abuses shall be prohibited and that "the wounded and sick shall be collected and cared for"[21].

The Protocols similarly prohibit torture and outline the role of health personnel in conflict. According to Protocol 1 of 1977, protection of medical personnel in international conflicts should be of the following kind:

Medical units shall be respected and protected at all times and shall not be the object of attack. (Article 12)
Civilian medical personnel shall be respected and protected. (Article 15)
Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom. (Article 16)

Protocol II of 1977 which applies to non-international conflicts, sets out the protection which should be afforded to medical personnel.

Medical and religious personnel shall be respected and protected .... They shall not be compelled to carry out tasks which are not compatible with their humanitarian mission. (Article 9)

Article 10 repeats the protection from punishment for acting in conformity with medical ethics which was stated in Article 16 of Protocol 1. However, Article 10 also says that while "no person engaged in medical activities may be penalised in any way for refusing or failing to given information concerning the wounded and sick ..." this principle is "subject to national law". In AI's experience there is considerable evidence that such "national laws" can be used to harass or even to prosecute doctors. The ICRC Commentaries also see this conditionality of confidentiality as a potential weakness.

[Article 10] provides that the professional obligations of those engaged in medical activities regarding information, which they may acquire concerning the wounded and sick under their care, must be respected, but always subject to national law.... This legal situation, the result of a compromise, has its shortcomings in that it might endanger the special protection to which the wounded and sick should be entitled.... An obligation to systematically reveal the identity of the wounded and sick would divest the principle of neutrality of medical activities of all meaning.[22]

The mechanisms for reporting violations of international humanitarian law are considerably weaker than those applying to international human rights law. There is no international equivalent of the Human Rights Committee of the United Nations; nor is there a Special Rapporteur on international humanitarian law issues. In practice the UN human rights apparatus does take note of human rights violations committed in a framework of armed conflict. However, neither the Geneva Conventions nor the Protocols specify what health personnel should do when they find evidence of human rights violations.

Persuading the medical professions that a more active response to abuses is necessary is not without its difficulties. When an Amnesty International delegate to the 1983 World Medical

[21]ICRC. *The Geneva Conventions of 12 August 1949.* Geneva: ICRC, 1989.

[22]*ICRC Commentary on Geneva Protocols* p.1428.

Assembly[23] raised the problem of medical involvement in human rights violations and spoke of the necessity for doctors to report colleagues assisting in torture, there was criticism from some participants who said that this was encouraging doctors to become "informers"[24]. Six years later at an international conference in Paris on *Medicine at Risk: the doctor as human rights abuser and victim*, a resolution calling on the WMA to enforce the Declaration of Tokyo with respect to South Africa was vigorously criticised by the then WMA Secretary-General who saw it as an unwarranted and unacceptable attack on a member association[25].

The gaps in human rights and humanitarian law referred to above arguably deprive doctors and other health workers of guidance in the face of potentially troubling moral conundrums.

Amnesty International and medical evidence of human rights violations

Amnesty International and many other human rights bodies have made increasing use of medical evidence in the documentation of torture and the campaign against it. AI's focus on the potential medical role in the defence of human rights came to the fore in the first AI Conference for the Abolition of Torture which took place in Paris in December 1973. One of the working parties at the conference examined medical aspects of torture and made a number of recommendations including the following:

> Medical and associated personnel shall refuse to allow their profession or research skills to be exploited in any way for the purpose of torture, interrogation or punishment...
>
> Medical personnel working in prisons or other security camps should insist that they be employed by, and responsible to, an independent authority.
>
> Medical personnel who know of instances [or] plans of torture must report them to the responsible national and international bodies.[26]

The first recommendation cited above is now embodied in international standards but the second and third remain to be formally adopted and put into practice.

In 1977, AI published a short booklet of studies carried out by the AI Danish Medical Group which documented medical evidence of torture[27]. Over subsequent years, AI published numerous reports in which medical evidence contributed to the exposure of human rights abuses[28] and there has been an impressive increase in the amount of literature currently available on the medical documentation of torture and different forms of health and psychosocial care for victims of this abuse

[23]The World Medical Assembly is the annual World Medical Association meeting of delegates from national medical associations.

[24]See Rodley N. *The Treatment of Prisoners Under International Law*. Oxford: Clarendon Press, 1987. p.299.

[25]The meeting was organized by the French *Commission médicale* of AI. For procedural reasons, the resolution on South Africa (and another single-country resolution) was not adopted but was left for individual signature outside the framework of the conference.

[26]Amnesty International. *Conference for the Abolition of Torture. Paris 10-11 December 1973. Final Report.* p.15.

[27]*Evidence of Torture*. London: AI Publications, 1977.

[28]*Iraq: Evidence of Torture.* London: AI Publications, 1981; *Uganda: Evidence of Torture.* AI Index: AFR 59/06/85.

and other human rights violations[29].

Amnesty International recommendations on medical safeguards

Amnesty International has repeatedly drawn the attention of governments both to their obligations to provide medical services to detainees and to make use of medical evidence in investigating allegations of human rights violations. It has also underscored the value to governments of having such evidence to protect them from false allegations. For example, in a 1989 report to the Government of Egypt, AI recommended that all arrested individuals be medically examined promptly after arrest and that:

> detainees should be offered regular subsequent examinations at least once a week, more often while under interrogation, and immediately before transfer or release; and they should be informed in writing of their right to each examination;

[29] *Bibliography of publications on health and human rights themes*. AI Index: ACT 75/03/93.

these offers should be made personally by a member of the medical staff on duty, who should explain the importance of having complete records of the detainee's conditions in detention;

all examinations should be conducted in private by medical staff only;

any refusal by a detainee to have such an examination should be witnessed in writing by the medical officer;

every detainee should have access to the medical officer on duty at any time on (reasonable) request;

detailed records should be kept by the medical staff of every examination and offer of an examination, and of such matters as a detainee's weight, body marks, psychological state and complaints related to health or treatment;

these records should be treated as confidential—as in any doctor-patient relationship—but should be available to be communicated, at the detainees' request, to their lawyers or families;

detainees or their lawyers or their families should be able to request examination by detainees' own doctors, without prison guards being present.[30]

Amnesty International has made similar recommendations to numerous governments, generally without such recommendations being implemented.

Effective medical evidence

In order to be effective, medical evidence bearing on cases of alleged human rights violations must conform to the following:

It must be obtained promptly: it is self-evident that the earlier one can investigate allegations of abuses the more intact will be the physical signs of such abuse and other relevant material and witness testimony.

It must be competently gathered: evaluating evidence of human rights violations can require the involvement of professionals with particular relevant skills and experience. Lack of training or experience in legal aspects of medicine and, particularly, lack of knowledge and practice in areas of trauma may lead to inadequate assessment of injuries and testimony.

It must be secured: if the evidence is to be fairly and competently evaluated, those carrying out such evaluations must be protected. This requirement also applies to victims and witnesses.

It must be accessible to relevant parties: the results of the medical evaluation must be made available to the victim and/or the victim's family and legal counsel; they must have the right to make it public if they so choose.

It must be open to challenge: the victim or his or her counsel must be able to seek an additional medical examination if, for whatever reason, they believe the initial medical evidence to be inadequate.

It must be obtained ethically: it is essential that process of obtaining medical evidence conform to the basic standards of ethics and human rights in defence of which the evidence is being gathered.

Amnesty International's principles for the medical investigation of torture are appended to this report (see Appendix 2, page 39). They embody the above approach to the use of medical evidence in cases where torture is alleged. Amnesty International believes that implementation of these principles could contribute to more frequent exposure of torture and to the more effective administration of justice.

[30]Amnesty International. *Egypt: Arbitrary Detention and Torture Under Emergency Powers.* London: AI Publications, 1989, p.37.

3. The health professional's role in exposing human rights violations

The principal task of health professionals is to care for patients. Their role in uncovering and exposing human rights violations is not their primary function but is nevertheless one which can flow inevitably from their exposure to the suffering of their patients and, as noted in the previous chapter, from the obligations imposed on them by their professional ethics and international human rights and humanitarian law.

This section looks at the ways in which health care practitioners can assist the detection, documentation and exposure of human rights violations.

The clinical examination of individuals alleging torture or other abuses

Ill-treatment can leave physical and psychological traces. A trained and experienced physician or other health professional can determine the presence of signs of trauma and evaluate their origins. Some physicians encounter torture or ill-treatment in the course of routine clinical practice; others examine individuals alleging torture with the specific aim of evaluating those allegations and of providing whatever clinical evidence can be detected.

Amnesty International has had long experience in the application of medical expertise to the documentation of torture. The principles underlying medical examinations for human rights documentation have been described in AI reports[31] and elsewhere[32]. Essentially, the medical evaluation of a witness's allegation of torture is based on a clinical interview and examination and comprises four elements:

(i) an attempt to assess the health of the person before their arrest. This may include evaluation of existing medical records but, in the context of fact-finding missions and examinations of asylum-seekers or refugees, is more likely to be based on the interview with the subject;

(ii) an account of the subject's experiences from the time of arrest to the time of release, with particular emphasis on the nature, frequency and duration of episodes of torture and ill-treatment, and the subject's recollection of the effect of these episodes on his or her health (both signs and symptoms);

(iii) examination and assessment of the subject's current physical and mental state;

(iv) a report evaluating the consistency between the allegations, the signs and symptoms at the time of the alleged torture as recalled by the subject, and the signs and symptoms at the time of examination. Additional background information on torture practices in the country of the origin may be helpful in assessing the testimony.

---

[31] *Chile: Evidence of Torture*. London: AI Publications, 1983.

[32] Randall GR, Lutz EL. *Serving Victims of Torture*. Washington DC: AAAS, 1991; PHR. *Medical Testimony of Victims of Torture: A Physician's Guide to Political Asylum Cases*. Boston: PHR, 1991; Rasmussen OV. Medical Evidence of Torture. *Danish Medical Bulletin* (Suppl. 1) 1990; 37:1-88; Petersen HD, Rasmussen OV. Medical appraisal of allegations of torture and the involvement of doctors in torture. *Forensic Science International*, 1992;53:97-116.

In many cases the physical evidence of torture is very slender due to the nature of the torture or the delay in the medical examination of the person alleging torture. In such cases, it may not be possible to base conclusions on visible torture-related injuries; they must be based on the coherence, consistency and credibility of the victim's account, on the description of the early post-torture symptoms and signs, and on the subject's present psychological profile and demeanour. Even when physical injuries are in evidence they are often non-specific in nature. To be accepted as evidence of torture they need to be consistent with the alleged ill-treatment and not consistent with self-infliction or natural causes.

An exchange of opinion between Egyptian forensic doctors and British doctors working with victims of torture illuminated some important issues relating to evidence of torture. At issue were allegations of torture made by defendants among 302 prisoners arrested in Egypt in October 1981 and prosecuted for various crimes related to terrorism. Of those on trial 190 were acquitted in a trial ending 30 September 1984. Following the allegations of torture which was alleged to have been carried out by police in the month following their arrest, a judge ordered the Attorney General to examine all cases of alleged torture of the defendants and to report promptly. A forensic team subsequently examined 267 defendants and submitted a report upholding the allegations in some cases. Senior officers were suspended and charged with the use of torture against 28 defendants.

The officers, who were now defendants in their own right, sought to introduce forensic evidence of their own and a second team of forensic experts reviewed the reports produced by the first. The second team criticised the findings of the first team, principally because of the lack of physical findings found by the first team which examined the prisoners in early 1983, more than a year after the alleged torture. In particular, they noted the lack of physical sequelae to torture including to two of the significant torture techniques used—"Palestinian hanging" (hanging by the wrists which are tied behind the back, and *falanga* or beating on the soles of the feet. As a result of their experience, members of the second team published an account of the problems relating to the documentation under the title "Torture allegations - are they always true?"[33]. While the validity of their critique of the original findings is a matter for debate, their rejection of the initial forensic findings did not accord with the court findings or AI's assessment of the case and their sceptical conclusions regarding torture did not accord with AI's experience. On the basis of their rejection of the findings of the original forensic team, they concluded their paper with suggested guidelines in approaching torture allegations. In essence, they concluded that torture allegations should be disbelieved in the absence of physical findings; moreover, in a group alleging torture, absence of physical findings on any member of the group "should suggest conspiracy". They added that uniformity of allegations "may also suggest conspiracy".

Responding to this article, Forrest and colleagues[34] from the Medical Foundation for the Care of Victims of Torture in London, pointed to the frequent lack of physical findings in highly

[33]Elfawal MA, Abdel-Asl AG, Ahmed RM, Saad FY. Torture allegations - are they always true? *Police Surgeon*, 1993; 43:26-28.

[34]Forrest D, Knight B, Gordon E, Hinshelwood G, Tonge V. Torture allegations - are they always true? *Police Surgeon*, 1993; 44:37-39.

credible victims of torture. They noted the transience of many physical signs of torture as well as the rarity of some of the gross signs reported in the literature and expressed concern that the guidelines suggested by Elfawal *et al* were "utterly misleading". They proposed guidelines which laid emphasis on detecting provable contradictions between testimony and physical findings before rejecting as false the allegations made. In a rejoinder, Dr Elfawal criticised this approach as apparently representing a belief that "torture allegations 'are always true' until proved otherwise" and urged "readers to take a neutral stand when examining such cases".

This exchange illustrated the difficulties in assessing torture allegations when a significant time has passed between the alleged ill-treatment and the examinations; when a large number of examinations have to be made in a short time; and where conclusions have to be drawn from limited medical records which may not have been prepared in ideal circumstances.

Interviews

Health personnel in the field can obtain valuable information even when unable to conduct proper medical examinations. Their training and observational skills can contribute to the evaluation of testimonies given to human rights investigators. Human rights organizations have recognised this fact and have frequently included medical personnel in fact-finding delegations both to carry out technical functions, but also to undertake interviews and other fact-finding and to assess the information they and other mission delegates gather[35]. Surveys carried out by health professionals can throw interesting light on the experiences of populations. For example, in July 1990, a team of four PHR physicians interviewed 24 households chosen by random sampling in five refugee camps or villages, three in the West Bank, and two in Gaza. The team asked household members about beatings, shootings, exposure to toxic gas, humiliations and similar issues to determine the cumulative totals of occupation violence and the context and nature of human rights abuses. They also sought to determine the psychological and health consequences of the violations within the family unit, over a 31-month period. The same organization surveyed the experience of human rights violations of forensic practitioners in Turkey where they found a high level of knowledge of the existence of torture in Turkey[36].

Document evaluation

In cases where material evidence related to human rights cases is obtained—documents such as medical or death certificates, ballistic reports, video footage and so on—analysis by experts can assist in the evaluation of their relevance to investigation of the abuses reported. An example of the extent to which documentation can provide powerful evidence of human rights violations in the absence of the body of the victim is provided by the case of a death in custody in Tunisia reported below (pp.18-19). In this instance a post-mortem report was sufficient to challenge the government account of a young man's death.

[35]Reiter RB, Zunzunegui MV, QuirogaJ. Guidelines for field reporting of basic human rights violations. *Human Rights Quarterly*., 1986; 8:628-53; Rasmussen OV, Helweg-Larsen K, Kelstrup J et al. The medical component in fact-finding missions. *Danish Medical Bulletin,* 1990; 37:371-4.

[36]Iacopino V. A study of physician involvement in human rights violations in Turkey. Paper given at the meeting "Caring for Survivors of Torture: Challenges for the medical and health professions", Cape Town, 15-17 November 1995.

Forensic investigation

Forensic medical skills have been applied to a range of human rights situations[37], including the autopsy of the remains of detainees who have died in custody or in other circumstances suggestive of deliberate killing; the forcible adoption of children born to "disappeared" mothers; the excavation and evaluation of grave sites; and the examination of individuals alleging ill-treatment.

Medical examinations as a protective measure

The medical examination of prisoners at the time of arrest and regularly during detention is a potential safeguard against physical and mental abuse. Amnesty International, for example, has suggested that detainees be offered a medical examination by a medical practitioner on arrival at a detention centre and that they should be given the opportunity of a medical examination each day while they are under interrogation and again before they are transferred from the detention centre[38]. It has recalled this protective measure in appeals to individual governments[39]. The United Nations Body of Principles (1988) which aims at the protection of anyone in detention also states that "a proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary"[40]. These recommendations are based on the belief that a clear medical record of the state of health of the detainee soon after arrest acts as a benchmark for the medical findings of examinations made at subsequent times during and after the period of custody. There is thus an onus on the authorities to account for any marked change in the prisoner's health during the period of custody.

While such a protective measure has a potential to guarantee the protection of human rights, it is not a panacea for effectively preventing torture but rather a starting point. The case of Erdogan Kizilkaya illustrates the way in which such an examination may fail to prevent torture but can provide the evidence of illegal ill-treatment. He was arrested in his family home on 4 August 1991 together with a female visitor[41]. On the first day of police custody he was medically examined and a certificate, dated 5 August 1991, was issued stating that he had no signs of injuries on his body. He was subjected to a variety of forms of torture including being suspended by the wrists, having electric shocks administered, being beaten, including on the genitals and an attempt was made to insert a truncheon in his anus. He was shown his female friend being tortured with electricity and threatened to "talk or we will do worse". On 9 August 1991, shortly before being brought before the prosecutor, he was examined by a doctor at the Aydinlikevler Health centre, authorized by the Ministry of Health to carry out forensic examinations. The resulting medical report stated: "Examination showed no marks of blows or force". However on arrival at the

[37]Thomsen JL, Helweg-Larsen K, Rasmussen OV. Amnesty International and the forensic sciences. *American Journal of Forensic Medicine and Pathology*, 1984; 5:305-11.

[38]*Torture in the Eighties.* London: AI Publications, 1984, pp.82-3.

[39]*Egypt: Arbitrary Detention and Torture Under Emergency Powers.* London: AI Publications, 1989.

[40]Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. Article 24. In: *Ethical Codes and Declarations Relevant to the Health Professions.* Third Revised Edition. London: AI Publications, 1994, p.85

[41] *Turkey. Erdogan Kizilkaya: Misleading medical report after torture*. AI Index: 44/157/91, 29 November 1991.

prison, officials were concerned about his health. At 9pm on 9 August 1991 a prison doctor examined Erdogan Kizilkaya and documented injuries due to blunt trauma, binding with rope and burns "possibly caused by electricity". The prison doctor recommended that he be transferred to Kayseri State Hospital where he was examined two hours later. The State Hospital reportedly confirmed the prison doctor's findings and in addition found bruising of the penis. In September he was released pending trial on charges of passive resistance to arrest and membership of an illegal armed organization. To Amnesty International's knowledge, no prosecutions were opened in respect of torture or the apparent issuing by doctors of misleading medical reports.

Even in the absence of an initial medical examination, there is some evidence that interrogators refuse or delay access of prisoner to a doctor because they do not want signs of ill-treatment noticed or because they do not want the prisoner to receive care. For example, Nazir Ahmad Sheikh was arrested in January 1995 in Handwar, Jammu and Kashmir. According to his testimony:

Figure **0**. Nazir Ahmad Sheikh in hospital in Srinagar, shortly after the amputation of both his feet and some of his fingers. © Pierre Zakrzewski.

I w a s t a k e n t o **I** n t e r r o g a t i o n C e n t r e

at Kalam-Chakla, where I was severely interrogated,

the modus-operandi of the interrogation was that I was

s

f
o
r
c
e
d

t
o

w
a
l
k

b
a
r
e
-
f
o
o
t

o
n

t
h
e

s
n
o
w

f
o
r

h
o
u
r
s

a
n
d

later on I was beaten with sticks inside the room...

There after I was shifted to Interrogation Centre, Lan

gate, where I was again forced to walk bare foot on t

h
e

s
n
o
w

f
o
r

h
o
u
r
s

a
n
d

t
h
e
r
e
-
a
f
t
e
r

m
y

f
e
e
t
s

w
e
r
e

b
u
r
n
t

w
i
t
h

B
h
u
k
a
r
i

[
a

s
t
o
v
e
]
.
.
.

M
y

l
o
w
e
r

l
i
m
b
s

d
u
e

t
o

t
o
r
t

u
r
e

b
e
c
a
m
e

t
o
t
a
l
l
y

n
o
n
-
f
u
n
c
t
i
o
n
a
l

[
a
n
d
]

a
t

B
a
d
a
m
i
-
B
a
g

h

I
n
t
e
r
r
o
g
a
t
i
o
n

C
e
n
t
r
e

a
t

S
r
i
n
a
g
a
r

.
.
.

m
y

w
o
u
n
d
e
d

f
e
e

t h a v e s t a r t e d d e v e l o p i n g i n f e c t i o n .[42]

He was held for 5 weeks by the Indian military, ostensibly for investigation into possession of arms discovered by officers, allegedly after the prisoner revealed their whereabouts during interrogation. Shortly after release the prisoner had both feet amputated at the Srinagar Bone and Joint Hospital. According to the Indian authorities the reason he developed the gangrene which necessitated the amputation was because, when challenged by a security patrol, he ran off into the snow barefoot, sustaining frost bite which progressively developed into gangrene. The Indian Government account does not state why he was not promptly brought before a magistrate nor why the security forces would not ensure that he received effective medical care while in detention for the frost bite affecting his feet. (Nor does it explain plausibly why a resident of a snowy mountainous region would walk outside barefoot in mid-winter.) More credible than the government account is

[42]See AI. *India: torture continues in Jammu and Kashmir*. AI Index: ASA 20/33/95, November 1995.

the prisoner's story that he was tortured and that the soldiers refused to allow him to be seen by a doctor either in the vain hope of covering up the injuries or simply to add to the detainee's suffering[43].

Doctors at the Bone and Joint Hospital had little doubt as to the origin of this kind of ill-treatment. One was quoted as saying, after another former detainee had had both feet amputated as a result of gangrene:

> [T]he victim was kept on ice for about nine hours resulting in frost bite and then acid was sprinkled on his feet and all his blood capillaries were lost in the process of brutal torture. The lack of medical attention also added to the problem and the result was gangrene[44].

In both the cases cited above, the soldiers holding the detainees fail to meet minimum standards of military behaviour towards those in their custody. Existing legal safeguards, enacted to ensure the protection of detainees, were not adhered to, confirming a pattern of disregard of legal norms prevalent in armed conflict situations such as that existing in Jammu and Kashmir.

Figure **0**. AI medical delegates examine one of the four young men tortured and disabled by members of the Kenyan Special Branch.

In Kenya in December 1994, a similar failure of legal safeguards occurred; the proper implementation of domestic law would have prevented an episode of torture or, failing that, would have exposed the torturers to legal investigation. Four young men were permanently disabled by Special Branch officers who tied them to trees in Dundori forest, near Nakuru, and beat them. Despite their injuries, they were not taken to hospital for six days. Two days later one of the four, Geoffrey Ndungu Gichuki, had an arm amputated after developing gangrene. Amnesty International medical delegates who examined three of these men in March 1995 found that they had:

> suffered permanent damage to their bodies, mainly their arms. They all had pronounced impairment of function of their hands. Two of them were especially incapacitated: one of them lost his right arm, the other lost the function of his left hand, and they both had reduced function of the remaining hand. They all had pronounced ligature marks on their arms as unequivocal causes of the damage described above. Self-infliction of the lesions described above is *not* possible.

In an apparent effort to avoid evidence of police torture being presented in open court these four men were never charged. They were released after being held in hospital under police guard for seven months[45].

Medical examinations of detainees are potentially protective not only for detainees. If the authorities seriously wish to defend themselves against false allegations of ill-treatment then medical examinations of detainees would contribute also to this end. In some countries, however,

---

[43] *Ibid*.

[44] *Valley Reporter* [Jammu and Kashmir], May 1995, cited in *ibid.*

[45] *Kenya: Torture, compounded by the denial of medical care*. AI Index: AFR 32/18/95, December 1995.

the flouting of due process would take away some of the protective value of such examinations. It is therefore imperative that reforms in the area of medical evidence must be accompanied by strengthening of the rule of law.

Other forms of human rights documentation to which health professionals contribute

Forensic medicine.
Forensic medicine is the application of medical skills to the elucidation of legal questions. It includes a number of areas of medicine including the evaluation of marks, scars and testimonies of the kind mentioned above. However, in a human rights context, the major contribution of forensic medicine is in the evaluation of circumstances of injuries and deaths. There are numerous cases of forensic reports unambiguously documenting extrajudicial killing. In many cases, however, this evidence is ignored or discounted by courts which uncritically accept evidence brought by the state.

Figure **0**. Faisal Barakat whose death was ascribed by the Tunisian authorities to a traffic accident. Eye-witness testimony and forensic evidence indicates he died under torture.

In some cases, the forensic report—while not categorically pointing to human rights violations —provides evidence to sustain such a view. For example, a young Tunisian member of an unauthorised Islamic party, Faisal Barakat, was seen by eyewitnesses in the custody of police in Nabeul on 8 October 1991. He appeared to have been tortured, and later the witnesses heard his cries and saw his lifeless body dumped in the corridor. On 17 October 1991, his family was informed by police that he had died in a traffic accident. Indeed, doctors in Nabeul carried out an autopsy on 11 October on the body of a man said to have died in a traffic accident. The report listed in point form the injuries on the deceased's body. They included numerous ecchymoses which were visible on inspection. The main findings on autopsy were pulmonary congestion and a perforation of the rectosigmoid junction of the bowel. The report concluded that the man whose body they examined had died of "acute respiratory failure related to extensive pulmonary congestion" [*une insufficence respiratoire aiguë en relation avec la congestion pulmonaire étendue.*] They made no comment on the probable cause of such injuries.

Asked to comment on this report by AI, Professor Derrick Pounder, Head of the Department of Forensic Medicine of the University of Dundee, Scotland, concluded that

> the autopsy report indicates that this man died as the result of the forceable insertion of a foreign object at least 6 inches [15 cm] into the anus. Prior to his death he had been beaten about the soles of his feet and buttocks. Other scattered injuries to the body are consistent with further blows. The entire pattern of injury is that of a systematic physical assault and very strongly corroborates the allegation of ill-treatment and torture that has been made.[46]

[46] Cited in *Medical concern: Deaths in custody - Tunisia*. AI Index: MDE 30/0/92, 19 March 1992.

Professor Pounder went on to say that explaining the death as the result of a traffic accident "has no credibility in the light of the autopsy findings".

The Government of Tunisia maintained its story that Faisal Barakat had never been detained and had died in a traffic accident, though in September 1992 the case was re-opened. The conclusions of the Tunisian doctors and those of Professor Pounder were referred to a panel of three Tunisian professors of forensic medicine to evaluate. The three argued that "[there was] no existence of a traumatic lesion to the anus and that there were no objective grounds for Professor Pounder's conclusions". The panel did not suggest how a healthy young man could sustain superficial and internal trauma of the kind documented in the report. In the face of this criticism, Professor Pounder re-affirmed his opinion and his findings were reviewed by other forensic experts from Britain, Denmark and France who concurred with his conclusions. Amnesty International has not yet received information about the resolution of this divergence of professional opinion. The case has been referred to the UN Committee Against Torture in the form of a complaint on behalf of the family of Faisal Barakat.

Grave sites.

The recovery of human remains and elucidation of their identity and the circumstances of their death is a specialised area of anthropology which has been applied with increasing frequency in human rights cases over the past decade. The first systematic application of forensic anthropology in a major human rights case occurred in Argentina following the end of military rule in 1983.The National Commission on Disappeared People, CONADEP, documented 8,960 cases of "disappearance" which occurred during the seven years of military rule; they stated that the figure was likely to be higher. Recent statements about treatment of the disappeared by former military figures have suggested that some of the "disappeared" were thrown into the sea and the remains may never be found[47]. In other cases, unmarked graves appear to hold the remains of former prisoners who were killed during the period of the "dirty war". A systematic approach to identifying remains in anonymous graves was made in the mid-1980s and subsequently by a team comprising US experts and Argentinian students. The latter group later formed the basis of the Argentina Forensic Anthropology Team which has applied its expertise to human rights cases in other countries[48].

Examination of grave sites is particularly vulnerable to various impediments. For example, preliminary efforts by well-intentioned but untrained personnel to recover evidence from a grave site may in fact lead to the loss or destruction of valuable information. Another major problem in the investigation of grave sites is that of access. In some cases authorities prevent access of anyone but approved personnel to the area of the grave site. At Ov_ara, near Vukovar, Croatia, a team from the Boston-based organization Physicians for Human Rights (PHR) undertook an exploratory excavation of the site of a mass grave in December 1992[49]**.** The grave is believed to contain the bodies of around 200 people, including patients, staff and others who were present in the Vukovar hospital when it was surrendered to the Yugoslav National Army (JNA) in November 1991 during

[47]See *Argentina: the right to the full truth*. AI Index: AMR 13/03/95, July 1995.

[48]Joyce C, Stover E. *Witnesses from the Grave*. New York: Bantam, 1991.

[49]Mass grave near Vukovar. *PHR Record.* vi(1), Winter 1993.

the war between the JNA and Serbian paramilitary forces on one side and Croatian forces on the other. The victims were abducted from the hospital by JNA soldiers and taken to Ov_ara where Serbian paramilitaries were also present. The initial excavation confirmed that many bodies were buried at the site and that the first two sets of skeletal remains appeared to be of males killed by gunshot. However, the Serbian authorities controlling the area obstructed later attempts to carry out a full exhumation at the site.

Nurses and other carers as witnesses.
Nurses are frontline health personnel. They carry out a wide range of practical caring functions, many of which take place in the absence of doctors. They are, therefore, potential witnesses to a wide range of abuses which may never come to the attention of a doctor. Moreover they risk coming under increased pressure to carry out unethical activities if doctors refuse to do so. Other health carers may also find themselves in the same position. In many countries health care is given by people without formal training and these individuals may also witness human rights violations and be at risk as a result.

A Peruvian nurse who witnessed a massacre in 1988—Marta Crisóstomo García—was found by military personnel and shot dead 16 months after the killings. Her death followed the "disappearance" of five, and the killing of three, other witnesses. She had unsuccessfully sought the protection of the Peruvian Attorney General before she lost her life.

Figure **0**. Peruvian nurse Marta Crisóstomo García was murdered 16 months after witnessing an army massacre. Her request for protection was ignored by Peru's Attorney General.

More generally, it must be assumed that many nurses are aware of violations which they know about from patients attending the clinics and hospitals in which they work. They have an important role in bearing witness to human rights violations they see though, as the story above underlines, they too need protection to play this role.

Professional associations
In general the role of professional associations is restricted to representing the professional interests of their members in negotiating salary, conditions and the development of health policy in a country, though in some countries they also have an role in professional registration. However, in countries in which human rights violations are significant the medical or nursing associations can promote the role of health personnel in protesting against torture and other abuses, support members who are under threat and promote an awareness of professional ethics both within their own membership and also among the public.

In the early years of the period of Chilean military rule, trade unions and professional associations were banned or strictly controlled. The Colegio Médico de Chile was one such organization[50]. It lost the right to elect its own executive officers and to act as an autonomous

[50]The Colegio Médico de Chile was a divided association at the time of the 1973 military coup with some regional doctors' groups having called for, and subsequently supported, military action against the elected government. See Hamilton G. Professionalism: Lessons from Chile. *Medicine in*

professional association. In the years immediately following the restoration of basic rights by the government in 1982, it commenced a vigorous campaign in defence of human rights and particularly against the use of torture and medical involvement in torture. It also helped organize treatment for those injured in clashes with riot police and supported doctors who were under threat because of their medical treatment of wounded members of armed opposition groups. The CMC was awarded the human rights prize of the American Association for the Advancement of Science in 1986[51].

In January 1995 that the Turkish Medical Association (TMA) reportedly initiated an inquiry into two physicians who prepared medical reports alleging that Ahmet Özçil had not been tortured while he was kept in custody at the Eskisehir Security Directorate on 25 December 1994. Four other physicians were said to have tried to "disguise" the reports verifying torture. A medical faculty dean was among those against whom an inquiry had been opened. Seven security officers were being investigated in connection with the alleged torture[52].

Other medical and nursing associations have acted with equal vigour to defend their professional integrity, the rights of their members to practice their professional calling ethically and, in some cases, to call for the release from prison of detained health professionals or for investigations into the deaths of those who die in custody.

The health professional as human rights observer

Health professionals are well placed to observe human rights violations and their effects first hand because of their role in the community, their access to prisoners, detainees and others held in institutions. Moreover, they have the skills to testify authoritatively as to what they see. Their professional ethics bring the moral and professional obligation to work for the benefit of their patients and not to collude with ill-treatment. Their clinical skills can allow them to document injuries and their possible causes. Their professional standing makes them credible witnesses. Their membership of the national and international professional community gives them some degree of protection which many others do not have. However, none of these factors are absolute. If health professionals are to play a protective, ethical role in the defence of human rights, certain factors must be guaranteed. The international community must make clearer its expectation of health professionals in this regard. National and international professional associations must set out clearly what their members are expected to do on encountering evidence of human rights violations. Governments must protect health professionals from pressure to collude in human rights violations. These basic requirements will be detailed below (pp. 32-36).

4. Failures in medical documentation of human rights violations

The problem of inadequate medical investigations

If medical examinations and investigations are to play any role in protecting prisoners certain

Society, 1981; 7:14-19;30-33.

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

[52] *Human rights, yesterday and today...* Daily bulletin of the Human Rights Foundation of Turkey, 26 January 1995, citing *Cumhuriyet.*

minimum prerequisites must be met. The doctor must have clinical independence, access to information, adequate professional training, reasonable workload, a clear understanding of medical ethics and human rights and, crucially, must be able to report fairly without fear of retribution. (The failure of courts to accept medical evidence is also of major significance and will be dealt with below.)

Unfortunately in many countries these minimum conditions are not met. While this may sometimes be a result of economic circumstances and lack of qualified personnel it is frequently an excuse rather than a reason; lack of political will or deliberate wish to impede investigation is a more credible explanation for inaction. The key reasons for inadequate medical investigations and reports are one or more of the following:

Lack of clinical independence.
In some circumstances, the health professional is not encouraged or permitted to make clinical judgments free from pressure to meet other non-health-related objectives imposed by others. At its worst this may be an instruction from a security or police agent that certain treatment shall not be given or that a report shall be written to conform with police or security objectives. It might also be pressure from colleagues not to "cause trouble". According to information given to Amnesty International, doctors at the government-funded *al Salmaniya* Medical Centre in Bahrain were warned by security authorities that if they treated any of those wounded during anti-government protests occurring during the first half of 1995, they would suffer repercussions [53]. The privately-owned Bahrain International Hospital did not receive the same direct interference but security personnel were stationed outside the hospital and harassed those who entered to seek treatment.

Ambulances were also prevented from taking some of the wounded to hospital. One ambulance worker told AI:

> Ambulance men are insulted by some of the officers while carrying emergency cases, such as people suffering heart attacks or severe respiratory problems... Orders are given by some officers to bring all cases to the entrance of Sitra [hospital] where policemen and their officers are stationed. Then an officer would examine the patient externally to make sure that he [was not one of those] wounded during the protests, and then he would allow us to take him...[54]

At least four wounded demonstrators died following the stopping of ambulances by security forces.

In Kenya, some police officers and members of the youth wing of the ruling Kenya African National Union (KANU) party regularly inflict gross suffering and injury on political and civil law detainees in the course of investigations. Medical reports on alleged victims of torture which document injuries would assist with the investigation of torture allegations. However this evidence is not readily available because of the harassment of both government and private doctors by the police and prison officials. As one doctor commented, "it is an open secret that the police have all

[53] Amnesty International. *Bahrain: a human rights crisis*. AI Index: MDE 11/16/95, September 1995, p.45.

[54] *Ibid*., p.45.

along been attempting to influence what doctors write in their medical reports, especially when it is obvious a suspect has been tortured"[55].

One Kenyan doctor stated:

> ...supposing, by the grace of God, you do finally gain access to the patient, the police will make sure they hear every word of what the patient is telling you. They will keep on interrupting during the interview. I have been asked [several times] why I was taking too many details about the injuries the patient sustained. At one time they even asked me whether I was recording statements or treating the patient....It the suspect happens to have been arrested for political reasons, the police will openly accuse you of being politically orientated. You are bluntly reminded that association with such individuals will most surely land you into problems. Some CID Officers asked me angrily at one time, "why do you have to take risks by treating such people?"....Many times I have been advised to stop writing medical reports on torture victims because as they would say, "you are making our work very hard, we can hardly pinch anybody because we fear you will write about it".[56]

Inadequate professional training or experience.
Some medical reports in human rights cases require advanced professional skills. This is particularly so in medico-legal contexts and unskilled doctors can be asked to perform a role which is beyond their capacity, irrespective of their good faith or lack of it. In some cases, autopsies are carried out by doctors with no specialised training in pathology, let alone forensic pathology.

However, it is sometimes difficult to know whether the root of the problem is professional inadequacy or deliberate incompetence. The Indian daily, *The Indian Express*, citing a report prepared by "a senior medical officer" at the request of the Inspector General of Prisons, gave the example of a prisoner who died in Tihar Jail, New Delhi on 16 March 1995. "[T]he prisoner had a heart disease which was missed not only at [initial examination] but also on subsequent check-ups. And the disease finally proved to be the cause of his death which was confirmed by autopsy". The report is quoted as criticising the initial medical examination given to all prisoners, noting that "except for the history of addiction or the information on record or volunteered by the prisoner himself, hardly any basic illness is diagnosed."[57]

Doctors in the southeast of Turkey told a delegation from the Turkish Medical Association that autopsies were carried out in the presence, and under the direction of the local prosecutor and that they were generally carried out by doctors with little experience in post-mortem examination. The TMA's report stated that: "Most doctors have said that they are not sufficiently experienced in autopsies and that therefore autopsies were directed by the prosecutors". It would appear that interference in autopsy procedures comes both from members of the security forces and from local prosecutors who, while formally charged with assisting the conduct of autopsies, appear on some occasions to impede them.

Excessive workload and lack of resources.

[55] *Kenya: Torture, compounded by the denial of medical care*. AI Index: AFR 32/18/95, December 1995.

[56] Cited in *ibid*. p.15.

[57] 'Avoidable medical deaths in Tihar, reveals probe.' *Indian Express*, 20 August 1995. The report was requested on 13 June 1995 following three deaths in the prison on 12 and 13 June 1995.

It is asking a lot of practitioners to add human rights cases to what may be an already over-stretched working day. Where health professionals are working with poor salaries and high workloads, and without necessary technical and personnel assistance, the chances of competent and accessible medical reports in human rights cases are diminished. An investigation into the pressures on medical staff in the southeast of Turkey found that the pressures on health personnel and the lack of security they encounter appear to have resulted in an exodus of health professionals from the southeast with a consequent shortage of personnel. The TMA delegation was told that in the town of _irnak, 49 health staff, of whom seven were doctors, left the area during the Kurdish new year period in 1992 without prior warning or formal resignation. According to the TMA report, in some towns there are no doctors and in others only a fraction of the normal quota. The pressure on those remaining increased proportionally. In other countries, low salaries, inadequate levels of staffing and general lack of resources compound whatever problems there are with government interference and pressure on medical personnel to refrain from protesting in cases of human rights violation.

Inadequate understanding of medical ethics.

Some doctors and other health professionals may see their role as providing a technical function in which medical procedures are carried out independent of ethical values. This may lead doctors or nurses to collaborate with interrogation, ill-treatment or even torture in the belief that as long as they personally do not inflict suffering their medical contribution is acceptable or even admirable[58]. In some cases national legislation promotes this technical role and risks encouraging the doctor to act unethically. In others, common practice leads to failures to address key issues in death investigations. In Brazil, for example, forensic doctors use a form requiring answers to a number of questions including the cause and means of death and the whether a certain number of specific circumstances, including torture or other "cruel" means were responsible. However, the emphasis in practice appears to be that in many cases cause of death is given only in a narrow technical sense and fuller details are often left out. This practice was explained by a former forensic doctor, Dr Harry Shibata[59], in testimony he gave to a hearing investigating the fate of prisoners who disappeared in Sao Paulo in the 1970s:

> Our function was purely technical. First thing in the morning we received bodies...and we performed autopsies to establish the cause of death...our task was only to establish the medical cause of death and not the judicial cause of death....[It] is purely descriptive...all that is on the body is observed and recorded. Now, the interpretation of these lesions is something we cannot give. A haematoma could be a spontaneous haematoma or it could be a traumatic haematoma. But we just describe the haematoma.[60]

Medical ethics calls for a greater accountability than meeting only the minimum requirements of the law or of common practice and demands that the doctor report any torture, particularly where is has led to the injury or death.

[58]British Medical Association. *Medicine Betrayed*. London: Zed Books, 1992.

[59]An attempt was made in 1980 by the Sao Paulo Regional Medical Council to discipline Dr Shibata for false medical certification in a human rights case but the decision was over-turned at federal level. ***Hearings on his case recommenced in 1995, along with those of four other doctors, and were continuing at the time of writing***

[60]Americas Watch et al. *The Search for Brazil's Disappeared: The Mass Grave at Dom Bosco Cemetery*. Washington DC: Americas Watch, March 1991, p.11.

Economic and other pressures.
Government employers have the power to exert pressure on doctors working in the public sector through threats of dismissal, downgrading or transfer. Those who work privately where official harassment could lead to a loss of patients which in turn could seriously affect their livelihood, can be reluctant to be seen as critics of the government. In Kenya, private doctors who attempt to treat prisoners frequently report difficulties in gaining access to their patients. Under rule 102 (3) of the prison rules,

> An unconvicted prisoner on remand...shall be allowed to see a registered medical practitioner appointed by himself or by his relatives...on any weekday during working hours in the prison, in the sight, but not in the hearing, of the officer in charge or an officer detailed by him.

However the officer in charge of the prison usually insists on a court order to allow the doctor to examine the patient, this order can take up to a week to obtain. The doctor may then be refused access unless the prison doctor is available which, given there are very few prison doctors, compounds ***delays. One doctor informed Amnesty International that despite the fact that the prison doctor and medical orderly were in the prison, both the doctor and a relative were kept waiting all afternoon without having access to their patient.*** The prison doctor informed them he was too busy. However, when the doctor asked to examine the patient in the presence of the medical orderly this was refused. Yet the following day the doctor was allowed to see the patient in the presence of the medical orderly. For private doctors, who have to close their clinics to make prison visits, seeing a patient in prison can be very time-consuming. It therefore has an impact both on their practice and on their income.

Reasons for failure of health professionals to effectively expose human rights violations

Lack of clinical independence
Inadequate professional training
Inadequate understanding of medical ethics
Economic pressures applied to health personnel
Physical or psychological pressure
Laws requiring medical assistance in HRVs
Government's ignoring of medical evidence

Overt physical or psychological pressure.
In many countries doctors and other health personnel come under direct pressure not to get involved in the cases of politically "undesirable" people. While governments have the right to implement appropriate security measures in the face of escalating violence, there are examples where doctors and other health personnel have been caught between opposing sides and appear to be victimised for exercising their professional function. In Peru and Turkey, for example, some doctors have been prosecuted by the government for "treating terrorists" and other health personnel have been under attack by opposition forces. In such circumstances the capacity of medical personnel to document human rights violations is put in jeopardy. Both the Turkish and Peruvian medical associations have conducted studies into the situation of doctors working in conflict areas in their respective countries and come to similar findings—that doctors working in areas of conflict are placed in an intolerable position to exercise their profession ethically.

On consecutive days in September 1992, Dr Nery Fermín Medina Quispe, aged 45, and Dr Fortunato Graciano Sumina Taco, aged 46, were arrested by members of the DINCOTE, the anti-terrorism branch of the Peruvian police. They were arrested while on duty at the Canamá Hospital in Arequipa Department after alleged members of the *Partido Comunista de Perú (Sendero Luminoso)* (PCP), [Communist Party of Peru (Shining Path)] accused them of having medically assisted a PCP member. They were also accused of having given financial assistance to an unidentified PCP member and to have been members of *Socorro Popular,* a social welfare group affiliated to the PCP. The allegations were made by alleged PCP members availing themselves of benefits provided for in Peru's anti-terrorist Repentance Law, which was in effect between May 1992 and November 1994. Among its provisions were clauses which benefitted members of the armed opposition who supplied information leading to the capture of other PCP activists.

Both doctors were active members of *Izquierda Unida* (IU), a legally registered coalition of parliamentary parties of the left. Members of IU have repeatedly been targeted by PCP members for their public rejection of the ideology and activities of the PCP. Some IU members have been threatened and killed by PCP members. IU members were further targeted when PCP prisoners began to accuse them of having links with the PCP by way of availing themselves of the benefits offered by the Repentance Law.

In a clear breach of the judicial principle that nobody should be tried more than once for the same criminal offence, Dr Medina Quispe and Dr Sumina Taco were prosecuted on the same charges twice. The second trial concluded before the first and they were each given sentences of 22 years' imprisonment by the High Court of Arequipa on 18 March 1993, sentences upheld by the Supreme Court of Justice in June 1993[61]. Local citizens and the mayor of Camaná as well as the region's Bishop, have written in support of the doctors stating that they have no links whatsoever with the armed opposition. The doctors have also received support from the *Federación Médica Peruana* (Peruvian Medical Association) and their cases were among those of a number of doctors raised by a World Medical Association delegation which visited Peru in November and December 1994[62]. Amnesty International is seeking the unconditional release of the two doctors whom the

[61]The 20 year sentence handed down by the first trial was overturned on appeal and a retrial ordered. In view of the conviction and 22 year sentence handed down at the second trial, this re-trial was not proceeded with.

[62]See: Report on a visit by a WMA mission to Peru during November/December 1994. *World Medical Journal*, 1995; 41:69-71, 1995.

organization has adopted as prisoners of conscience[63].

[63]Other Peruvian health workers have also fallen victim to the Repentance Law. Santosa Layme Bejar, who helped to run a women's and children's

health project in her community, was detained in February 1994 in her home district of San Juan de Lurigancho, Lima, the capital. She was arrested after being named by a detained member of the PCP. Amnesty International adopted her as a prisoner of conscience and urged the Peruvian authorities to release her immediately and unconditionally (see *Santosa Layme Bejar, Peru,* AI Index: AMR 46/17/94, 10 October 1994). In February 1995, after a year in detention, she was released, following a High Court decision that there was no case to answer.

Health professionals working in areas of Colombia affected by the long-running civil conflict are faced with enormous difficulties in carrying out their humanitarian duties. Doctors, nurses and paramedics have been subject to threats, harassment and physical attacks by the Colombian armed forces, their paramilitary allies and armed opposition groups. Health professionals have been one of the sectors affected by a severe escalation in political violence in 1995 in the region of Urabá in north-west Colombia where the armed forces and paramilitary groups are fighting three guerrilla organizations for control of territory. Clashes between the armed groups are rare. Most attacks have targeted sectors of the civilian population, including health workers, believed to be supporting or assisting members of rival armed groups. Dozens of doctors and other health professionals have fled Urabá after receiving threats. Their departure has produced a severe shortage of trained medical staff in the region. As one doctor told Amnesty International, "We are in the middle of a war and you never know which side the bullet is coming from. We are not prepared for this".

In Kenya, the prevention of medical exposure of human rights violations appears to operate more through economic pressures and general political menace. Private doctors in Kenya, who are not liable to the direct threats to their position which affect government-employed doctors, are, like their public sector colleagues, also harassed and intimidated and at least one private practitioner has been imprisoned for several days for writing medical reports on political prisoners. On 20 November 1993 Dr SK Mwangi, who had been giving medical treatment to political prisoners recently detained, was arrested. He was due to present a medical report to the court on Koigi Wa Wamwere and four others, including Geoffrey Kuria Kariuki who was ill with typhoid, on 22 November 1993. Dr Mwangi was held incommunicado for three days before being charged with sedition and possession of explosives and released on bail. He denied the charge and it was later dropped. Amnesty International believes that his arrest was really due to his attempts to arrange independent medical treatment for these prisoners. Another doctor, a human rights activist, had attempted to visit these prisoners shortly after their arrest and had been denied access and threatened by the police.

A Turkish Medical Association (TMA) delegation to the southeast of Turkey in 1992 reported that the main problem facing doctors working under the State of Emergency was in the area of forensic medical reporting. Many of the doctors interviewed told the delegation that they felt considerable pressure to issue reports which would comply with the wishes of the authorities. They reported that members of the security forces bringing detainees for examination generally remained present in the examining room. Doctors reported that they were often afraid to ask security personnel to leave the room and afraid to make an objective statement of their findings. The TMA's report noted that:

> The uncertainty created by the pressure in forensic medicine centres is so high that reports made by the same doctor about the same patient can vary from one day to the next, or, similarly, different doctors issue completely disparate reports about the same patient.

The delegation noted that, in addition to pressure from the security forces, doctors in the region were also concerned by the absence of adequate skills in post-mortem examination and by interference in autopsies.

Laws requiring medical participation in human rights violations.
In exceptional cases health professionals can be required by law to *commit* human rights violations. For example, in Pakistan the *Qisas* and *Diyat* Ordinance permits cruel, inhuman and degrading punishments in so far as it requires under certain conditions that the punishment for specified offence be *qisas*, equal punishment for the offence committed. If the *qisas* punishment involves amputation, the participation of a medical officer in implementing such punishment is required[64]. The *Qisas* and *Diyat* Ordinance has been re-promulgated every 120 days since it was first introduced in September 1990. In 1995, the government of Pakistan announced its intention to introduce legislation to ban whipping as a punishment in specific cases though at the time of writing, no bill has been submitted to the legislature. There is no suggestion that the bill will remove the requirement of doctors to assist in the carrying out of punishments in contradiction of their healing role[65].

Figure **0**. Pakistani law requires doctors to transgress medical ethics on behalf of the state by assisting at the infliction of corporal punishment. © Popperfoto.

Even more alarming was the introduction in Iraq in 1994, of a series of government decrees providing draconian penalties for the crime of theft. The penalty of "amputation of the right hand at the wrist for a first offence, and of the left foot at the ankle for a second offence" was brought into law by Resolution 59 of the Revolutionary Command Council on 4 June 1994. Resolution 74 of 23 June 1994 widened the scope of punitive amputation to include currency offences deemed to "constitute sabotage of the national economy or to be highly damaging to the national interest". On 28 July 1994, the Revolutionary Command Council adopted Resolution 96 which provided that punitive amputations "must be performed in a public hospital specified by the Ministry of Health in Baghdad and in each province". Moreover, "the public hospital where an amputation is to be carried out must be equipped with the necessary tools to facilitate the execution of the sentence". Dispensation was made for condemned pregnant women whose sentence would be deferred "until four months after childbirth".

On 18 August 1994, resolution 109 was adopted, specifying that a victim of punitive amputation would be branded on the forehead with a cross and that this would be carried out in the [appropriately equipped] public hospital where the amputation took place. A week later, military deserters or those assisting them became liable to "severance of the external part of the ear" and branding "with a straight horizontal line" on the forehead. A separate resolution adopted the same day provided for amputation of the hand or ear, and branding of any doctor attempting to remove the brand or attempts at plastic surgery on the amputated hand or ear of a victim of this punishment. Amnesty International, other human rights organizations and the World Medical Association

[64] *Pakistan: New forms of cruel and degrading punishment,* AI Index: ASA 33/04/91, 1991.

[65] *Pakistan: Appeal to ban public flogging,* AI Index: ASA 33/25/95, November 1995. The Pakistan Medical Association (Karachi Branch) has, on a number of occasions, protested at the legal requirement for medical personnel to participate in cruel punishments.

protested at the introduction of this legislation[66].

[66]On 18 January 1996, Reuters quoted Iraq's Justice Minister, Shabib al-Maliki, as saying that "the law concerning the cutting of ears is now null

and void". He was said to expect that other mutilatory punishments would soon be abolished.

A draft bill proposed by the Israeli Government in 1995 to amend Israeli Penal Law relating to the prohibition of torture could also place health professionals in the position of being accessories to human rights violations. The Prohibition of Torture bill was drafted by an inter-ministerial committee established to incorporate the UN Convention against Torture into Israeli law. While the proposed amendment states that a public servant who tortures or authorizes torture is liable to between 10 and 20 years' imprisonment, the bill defines torture as "severe pain or suffering, whether physical or mental, *except for pain or suffering inherent in interrogation procedures or punishment according to the law*" (emphasis added). Such wording effectively sanctions ill-treatment and is contrary to the UN Convention. The UN Committee against Torture, a body of experts set up to monitor the implementation of the Convention against Torture, has previously criticized Israel for its "clear failure to implement the definition of torture as contained in Article 1 of the Convention".[67]

[67] See: *Death of Abd al-Samad Harizat and government statements on the use of pressure during interrogation: Israel and the Occupied*

Territories. AI Index: MDE 15/35/95, 5 December 1995.

Absence of, or wholly inadequate, investigation of human rights violations

In many countries investigations into alleged abuses in certain, often politically-sensitive, cases are marked by their total absence or gross inadequacy. In Mexico City, Félix Fernández and Demetrio Hernández were arrested on 20 October 1994 by the Federal District judicial police and brutally tortured to extract confessions. The torture included long periods of electric shocks, semi- asphyxiation, beatings, and threats that they and their relatives would "disappear" or be killed. They were forced to confess to involvement in a bomb attack in the city centre in January 1994. Their arrest was ordered by a public ministry officer in the Federal District, without approval of a court, and the torture reportedly took place in a secret detention centre. In January 1995 an Amnesty International delegation visited the *Reclusorio Preventivo Norte* where they were held. Two doctors in the delegation, including Professor Jørgen L. Thomsen, a Danish forensic pathologist, interviewed and examined both detainees. Both men had been denied any adequate medical care during police custody and in prison. The doctors they had previously seen had failed to certify injuries which could have helped substantiate charges of ill-treatment against the police. One of the certificates prepared by a forensic doctor stated that the injuries occurred 48 hours before their arrest, while another stated "there were no recent physical marks present" (*"No presentan huellas corporales físicas recientes"*).

The Amnesty International delegation, however, was able to identify several injuries on both men, including scars of electricity burns, which were consistent with the torture they described. Furthermore, as Dr Thomsen commented:

With regard to recent lesions, without a biopsy it is usually impossible to distinguish if the lesion is one or two or even three days old. Therefore it is difficult for me to understand how the forensic certificates [as described above] could establish with certainty that the lesions on the two men were sustained before 20th October.[68]

In this case the performance of the forensic doctors responsible for the examinations of the men alleging torture were clearly inadequate and the reasons for this inadequacy appear to be self-evident: deliberately false reporting in order to relieve those responsible for torture of accountability.

The speculation and confusion provoked by unsatisfactory death investigation procedures can be glimpsed from press accounts of the deaths of six Sikh men in Lucknow in November 1994. According to these reports[69], 28 men held under the Terrorist and Disruptive Activities (Prevention) Act, were the subject of torture and severe ill-treatment; six men died as a result[70]. Officials were cited as suggesting that those killed had been shot while trying to escape. However a post mortem report was said to have shown that the six died "of genital injuries caused by blunt objects". The report did not indicate who carried out the post-mortem nor where it was carried out. It did indicate that the prison doctor was asked to undertake the autopsies but that local Sikhs, on hearing of the killings, rushed to the hospital thus "prevent[ing] the jail doctor from destroying evidence". Whether this is a fair representation of events is not clear. What the reports do reveal is that the lack of clear, open and publicly-accepted procedures for the investigation of allegations of torture and of deaths in custody leads to public frustration and lack of faith in those investigations which are carried out.

Larger scale inadequacies were observed in Algeria where at least 96 detainees were killed by security forces in a reported mutiny in Serkadji Prison at the end of February 1995. Four guards and one member of the security forces were also killed. There are allegations that many of the detainees were deliberately extrajudicially executed, including after they had returned to their cells. The vast majority of those killed were political detainees accused or convicted of "terrorist activities". The families of the victims were informed of their deaths only after they had been buried. No autopsies were carried out to establish the circumstances and causes of death, and most of the dead were buried as "X Algérien", without having been identified.

An inquiry carried out by the official human rights body, the *Observatoire national des droits de l'homme* (ONDH: National Observatory for Human Rights), with the participation of the Union Médicale Algérienne (Algerian Medical Union) failed to investigate the circumstances in which the detainees were killed. The ONDH claimed that the dead detainees had been photographed before being buried to allow for post-burial identification, but it refused to show the photographs to families and lawyers of the victims or to Amnesty International and other international human rights organizations. The list of detainees killed had still not been made public by the end of the year. Amnesty International delegates visiting Algeria in March and June 1995 were denied access to

[68] ***Mexico: Human rights violations in Mexico: A challenge for the nineties. AI Index: AMR 41/21/95, November 1995.***

[69] '6 tortured to death in Philibhit jail.' *Telegraph* [Calcutta], 16 November 1994; 'Philibhit police try to fake post-mortem.' *Telegraph*, 17 November 1994.

[70] This Act is no longer in force. It expired on 23 May 1995.

Serkadji Prison.

No investigation was carried out into a similar incident in Berrouaghia Prison in November 1994, when scores of prisoners were reported to have been killed by the security forces following a prison mutiny. Families of detainees killed in the incident have to date not been informed of their place of burial.

Ignoring of medical evidence

Amnesty International knows of hundreds of cases in Turkey of alleged torture during incommunicado detention, many supported by medical evidence, in which no judicial investigation was made, nor prosecution opened. Those who are persistent enough to bring their allegation to court face proceedings which almost invariably take years and result in negligible sentences for the torturers. Mediha Curabaz, a nurse who was tortured and raped with an electric truncheon in detention at Adana Police Headquarters in August 1991, made a formal complaint supported by a medical report. Her prosecution was blocked[71] by a decision of the Adana Provincial Governor's office (which is also responsible for supervising the police and gendarmerie). Mediha Curabaz's objection to the Appeal Court was rejected. However, she also filed a civil suit for the injury she sustained in police custody. She won this case and was awarded a small sum in compensation.

In October 1992 nine women and girls, one aged just 11 years old, were reportedly raped in the Indian village of Shopian by an army unit searching for armed separatists. Despite detailed medical evidence supporting reports by civil liberties groups that the women had been raped, the authorities dismissed the allegations, informing Amnesty International that they "were trumped up at the instance of the militant outfit to malign the reputation of the security forces". They based their denials on two investigations, one carried out by the army and the other by a Superintendent of Police. Questioned by *The Observer* (London) shortly afterwards, the Director General of Police, Commander B.S. Bedi, also dismissed reports of rape with this characteristic response: "We carried out investigations of the allegations and they were found to be wrong. These women were wives of militants". In December 1993, Amnesty International reiterated its appeal for an independent investigation, saying:

> The lack of an independent and impartial investigation into the allegations, for which there is substantive evidence, continues to cast doubt on the government's assertions that the alleged rape by members of the security forces did not take place.[72]

[71]The complaint was blocked under the terms of the Law on the Prosecution of Civil Servants which was in force in Adana at the time of her torture. Although this law no longer protects police throughout the rest of Turkey, any complaint of ill-treatment, torture, theft, rape, manslaughter—indeed any crime apart from intentional murder—made against a police or gendarmerie officer within the provinces under emergency legislation must first be approved by the local governor's office. In many towns in southeast Turkey, the deputy governor is the chief of the gendarmerie.

[72]Amnesty International has published two documents on the incident: *New allegations of rape by army personnel in Jammu and Kashmir*, January 1993 (AI Index: ASA 20/02/93) and *Comments on the government's response to allegations of rape in Shopian, Jammu and Kashmir*, December 1993 (AI Index: ASA 20/47/93). The latter concluded: "In Amnesty International's view, the medical evidence of recent sexual intercourse in these cases and the associated signs of violence constitute *prima facie* evidence of rape. Taking into consideration the statements of witnesses and other circumstantial evidence such as their ages, marital status and their signs of emotional distress at the time of interview, the allegations of rape are compelling and merit independent and serious investigation".

To date, Amnesty International has not received a reply.

The picture that emerges from the above is that medical evidence and positive action by health professionals to expose human rights violations are inhibited by pressure brought to bear against personnel who are aware of abuses but are prevented from denouncing them through a variety of mechanisms including direct political, economic or military pressure. In some cases health workers actively collaborate in abuses. There is a vital need for professional associations, human rights organizations and the international community to address this failed potential in ways suggested in the next section.

5. Conclusions and recommendations

1. There is ample evidence that medical fact-finding and documentation has contributed to exposure of human rights violations and to the prevention of further violations. This contribution by health professionals should be strengthened and widened.

2. There is equally ample evidence that this role is not meeting its potential due to a number of factors including

- fear by health professionals that they will be prosecuted or harassed for accurately documenting human rights violations;
- application of economic pressure on health professionals—threats of, or actual, dismissal, transfer, blocking of promotion or downgrading;
- inadequate training of health professionals in the methodologies of documentation of torture and other abuses
- inadequate understanding of professional ethics which prohibit collusion in abuses.
- willing or reluctant collusion by health professionals in the infliction of human rights violations against detainees and prisoners;

3. Governments and professional associations have not adequately addressed the potential and the failures of the health professional role in defending human rights and exposing violations.

Some governments have attacked health professionals for their professional or human rights activities or have defended doctors and others who have been involved in torture.

Professional associations, while adopting some excellent ethical standards, have, with a few exceptions, given less commitment to the need to monitor and enforce these standards. They have not sought to improve the existing standards to meet this lack.

4. Some inter-governmental organizations, while generally sensitive to the important potential role played by health professionals in the defence of human rights, and the occasional abuses by health professionals, could increase their commitment to improved medical documentation of human rights violations and to the concomitant need to protect personnel playing this role. To this extent the call by the UN for forensic scientists to make themselves available for human rights

investigations is to be welcomed[73].

The World Health Organization, which has undertaken a human-rights-oriented approach to the control of AIDS and HIV, has undertaken only modest initiatives in other areas of human rights and giving a higher priority to the defence of health professionals under threat for carrying out the ethical practice of their profession would be entirely consistent with WHO's goal of health for all.

Recommendations:

To the United Nations

1. As the inter-governmental organization responsible for the elaboration and monitoring of international human rights law, the United Nations should strengthen mechanisms for the reporting of human rights violations and investigate mechanisms for the protection of those involved in the documentation and reporting of human rights violations, including health personnel.

2. The United Nations should publish guidance for the medical documentation of human rights violations. The *Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions* represents an important precedent for this. The AI Principles for the Medical Investigation of Torture is a tool which could be adopted and further disseminated by the UN.

3. In the context of its regular programs of documenting human rights violations, the un should take particular note where human rights abuses are assisted by the failure of health personnel to carry out effective investigations. Such failures could be brought to the attention of the governments concerned as well as the appropriate professional association.

To the World Health Organization

1. Human rights violations are a significant factor in reducing the wellbeing of thousands of people around the world. Any strategy for "health for all" must include a commitment to action to prevent such violations and to expose and bring to justice the perpetrators.

2. The WHO should examine its own role in the elaboration of standards for the involvement of health professionals in the documentation of human rights violations and for the protection of health personnel playing such a role.

To national governments

1. National governments should declare an unconditional prohibition of torture and other cruel, inhuman or degrading treatment, if they have not done so already, and declare a commitment to the protection of human rights. National governments should take concrete measures to bring perpetrators of past human rights violations to justice, to adequately compensate the victims, to ensure that no one at present in detention is subjected to torture, extrajudicial execution or

[73]"Human rights and forensic science". Resolution 1994/31, adopted by the UN Commission on Human Rights, 4 March 1994; "Human rights and forensic science: Report of the Secretary General, E/CN.4/1994/24, 7 February 1994.

"disappearance" and to put safeguards in place to prevent their recurrence in future. Governments which have not yet done so should ratify relevant international instruments, particularly the Convention Against Torture.

2. Governments should establish adequate mechanisms to carry out prompt and impartial investigations whenever there is reasonable ground to believe that an act of torture has been committed. Among the measures which could be employed to this end are those elaborated in the UN *Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions* and the principles for the medical investigation of torture contained in the appendix to this report.

3. Amnesty International believes that a formal separation of authority between those responsible for detention and those responsible for interrogation of detainees in order to maximise protection for detainees. There should also be clear chains of command within the police which indicate who is responsible for supervising interrogation procedures and for disciplining officers who violate these procedures. At the moment of arrest, or very soon after, prisoners should be informed of their rights, including their right to lodge complaints against their treatment.

4. Medical examinations should be regularly provided for detainees and prisoners and should be performed by independent professionals under the supervision of a professional association, in accordance with the following principles:

- A medical examination should be carried out on each detainee promptly after arrest and before interrogation.
- Detainees should be medically examined every 24 hours during the period of interrogation; on a frequent and regular basis throughout detention and imprisonment; and immediately before transfer or release.
- The examinations should be performed by the doctor acting with full clinical independence, who should explain to the detainee the importance of having a full and contemporary record of his or her condition.
- Detainees should be informed of the importance of these examinations in verbal and written notice of their rights.
- Examinations should be carried out in private, exclusively by medical personnel. Special care should be taken to ensure that the examinations of women prisoners are carried out in an acceptable manner.
- Each detainee should have access to a medical officer at any time on the basis of a reasonable request.
- Detailed medical records on detainees should be kept and should include weight, state of nutrition, visible marks on the body, psychological state, and complaints about health or treatment received.
- These records should be confidential but should be communicated, at the request of the detainee, to a legal adviser, his or her family, or the authorities charged with investigating the treatment of prisoners.
- Each detainee should be entitled to medical examination by his or her own doctor at the request of the detainee or the detainee's lawyer or family.

5. Governments should ensure that those responsible for human rights violations are punished. The

role of health professionals in abuses or in their cover-up should be investigated and those found guilty of illegal actions should be prosecuted.

6. Where they do not exist, forensic services should be established with the goal of providing impartial expertise for the investigation of crimes including human rights violations. Such services should be adequately funded and independent of police or other law-enforcement agencies.

7. Post-mortem examinations should be carried out by independent doctors, preferably experts in forensic pathology, on the bodies of all those who died in custody. The post-mortem report should state the cause, manner and time of death and account for all injuries on the body, including any evidence of torture. The family of the deceased should have the right to have a representative present at the autopsy and should have access to the post-mortem report immediately on completion.

8. The independence and safety of health professionals should be protected by the institution of a clear separation between the law enforcement and security services and medical and medicolegal services, and by government guarantees to protect all those involved in the investigation of human rights violations.

9. Governments should ensure that all personnel connected with law enforcement should receive adequate training on human rights standards, both domestic and international, and on the means for their protection. This should include training in the prevention of human rights violations, medical ethics and prisoner's rights. It should also be given to all prison personnel, including medical personnel.

To international professional associations

1. International associations should declare forcefully that health professionals have an important role in the prevention and exposure of human rights violations—a role implicit in their professional ethics.

2. Associations should declare their support for individual health professionals reporting human rights violations and intervene on their behalf when they come under threat for speaking out against such violations.

3. International associations should investigate possible improved mechanisms for the protection of health professionals under threat for their legitimate professional or human rights activities. These could involve the establishment of an urgent appeal system to ensure that governments are contacted immediately after receipt of a credible report of a health professional under threat; encouragement of national associations to keep international associations informed and to intervene on behalf of their members; and more active cooperation with human rights and humanitarian organizations.

4. Associations are urged to state their support for the AI principles for the medical investigation of torture. They could add their voices to those urging their adoption as an international standard.

To national professional associations

1. Professional associations should make clear to their members that they are expected to act in conformity with national and international professional ethics. They should be assured that any legitimate action that they take to expose human rights violations which they encounter in their professional work will be supported by the association.

2. Associations should investigate allegations brought to their attention that health professionals have assisted in human rights violations or have helped in their cover-up. Those found culpable should be subject to appropriate discipline.

3. Professional associations should make all reasonable representations to their national government to end human rights violations and, in particular, to end those violations perpetrated against their membership and against those seeking the help of their members.

4. Associations should work to improve the teaching of medical ethics and human rights to students in relevant disciplines in universities and colleges.

5. Associations should undertake, consistent with their available means, a program of international solidarity with fellow professionals at risk of, or suffering, human rights violations as a result of their ethical pursuit of professional or human rights objectives.

Appendices: 1. AI action in support of health professionals
2. AI Principles for the Medical Investigation of Torture;
3. AI Declaration on the role of health professionals in the exposure of torture and ill-treatment.
4. Extracts from Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions.
5. Extracts of relevant ethical codes.

Appendix 1:AI action in support of health professionals: 1986-1995

In the almost 10 year period since 1986 (to October 1995), AI has encouraged action by the health professionals network on nearly 200 cases covering around 400 named professionals in 55 countries as well as scores of additional unidentified individuals at risk.

There have been significant trends over the past decade, with imprisonment for attempted "illegal exit" from countries decreasing in significance (though not disappearing) as a result the political changes in eastern Europe, and other abuses arising from ethnic or political conflict increasingly appearing.

While in many cases it is not possible to summarise simply or unambiguously the reason for harassment or punishment, it has been possible to establish a broad categorisation of human rights violations against health professionals based on the apparent cause of the violation. Table 1 shows these data.

It presents a selected and minimum picture of repression of health professionals, which does not include common measures such as dismissal, economic penalties, or general harassment but importantly does not exhaustively document all serious abuses—only those cases on which AI health professionals appealed. The most common type of violation upon which AI took action was extended detention (>1 week stretching to more than 15 years). Torture and disappearances were also serious concerns with short-term detention, death threats and executions also significant abuses.

The main factors which seemed to precipitate the human rights violations against the health professionals in this sample were political activities or beliefs and professional activities (including giving treatment to opposition activists). A significant minority appeared to be targeted for their human rights activities. The reasons for human rights violations were not always evident though it is likely that the large number of "unknowns" would translate in practice into either political or professional activities. The analysis does not distinguish between attacks specifically targeted on the health sector within society and those in which health professionals are a mere inevitable victim of a wider repression or in which the profession of the individual is irrelevant. In Rwanda, for example, health workers were among the victims of the massive killing in 1994[74] but were killed with apparently no less discrimination than others in the population. In other countries, doctors as individuals appear to merit special attention for their professional or human rights activities[75]. The

[74]African Rights. *Rwanda: Death, Despair and Defiance.* London: African Rights, 1994.

[75]Amnesty International. *Medical concern: Dr Beko Ransome-Kuti, Nigeria.* London: AI Index: AFR 44/21/95, 19 September 1995.

countries on which AI has most frequently issued appeals following reports of HRVs against health professionals—Chile (up to the end of the dictatorship in 1990), Turkey, Syria and Sudan (since the 1989 coup)—are also countries with bad human rights records and it is not surprising to see health professionals among the victims.

The experience of Amnesty International over a prolonged period of analysis and campaigning is that health professionals are in a position to contribute to the protection of human rights through their professional skills and activities and at the same time are vulnerable to pressures arising from that role. The international community of health professionals needs to address the issue of protection of colleagues at risk as well as promoting a wider awareness of, and commitment to, the role of health professionals in the protection of human rights of all people.

TABLE: Human rights violations (HRVs) against individual health professionals (HPs): Summary of AI medical actions 1986-1995

HPs subject of AI appeals		*Types of, and reason for, violation*	
Number by Region	**Number by profession**	**Types of violation**	**Apparent reason for HRV**
Africa (105+)[a]	doctor[b] (254+)	detention >1 week (****)[c]	political views/activity (****)
Americas(54+)	medical specialist[d] (44)	torture (***)	unknown (***)
Asia (18)	nurse (18)	death in custody/killing (**)	professional activity (**)
Europe (36)	health assist. (43+)	disappearance (**)	human rights activity (*)
Middle East (185+)	student (28)	detention <1week (*)	attempted "illegal" exit/entry[f]
(total=398+)	other[e] (11)	death threat (*)	ethnicity[e]
		execution (*)	

[a]The numbers given represent named individuals; a '+' indicates that a further unknown or undefined number of health professionals were the subject of AI appeals (where for example AI is unable to determine the full number of detainees).
[b]The term "doctor" is used as reported to AI; it is likely that some of these will be specialists and that the number of specialists is underestimated.
[c]Types of, and reason for, violation are indicated schematically by a scale of * to ****
[d]Psychiatrists and surgeons were the specialists most commonly recorded.
[e]Includes practitioners in psychology, veterinary science, dentistry, and pharmacy.
[f]A few cases were noted in these categories

Appendix 2:Principles for the Medical Investigation of Torture and Other Cruel, Inhuman or Degrading Treatment

Preamble: A number of human rights standards call for the prompt investigation of allegations of torture or other cruel, inhuman or degrading treatment by relevant authorities. These include the UN Declaration on the Protection of All Persons from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment, regional treaties, and a number of statements adopted by doctors' and nurses' organizations. Such an investigation should be carried out by an appropriate individual or commission having powers to interview witnesses, review prison or police procedures and employ expert assistance. One of the important resources in such investigations is suitably qualified and experienced medical personnel. The principles set out here represent basic steps in the medical investigation of torture and ill-treatment.

1. Prompt Access to a Doctor

A detainee or prisoner should have prompt access to a doctor when an allegation of torture or ill-treatment is made or when there is suspicion that torture or ill-treatment has taken place. Such access should not be dependent on the institution of an official investigation of torture allegations.

2. Independence

The examining doctor should be independent of the authorities responsible for custody, interrogation and prosecution of the subject. He or she should, if possible, be experienced in the examination of individuals for legal purposes. The doctor's affiliation should be made clear to the prisoner and should be recorded in the final medical report. Where an independent doctor is not available, the doctor carrying out the examination should nevertheless comply with these principles.

3. Confidentiality of Examination

The examination should take place in a room where confidentiality is ensured. The doctor should speak to and examine the subject alone. Where the subject is a female, a minor or a specially vulnerable person, examination should only take place in the presence of a witness acceptable to the subject. Where an interpreter is required, or the examining physician wishes to be assisted by an colleague, their presence should be dependent of the agreement of the subject. Any other third parties present should be asked to leave the examination room. If a third party refuses to leave, the doctor should note the name and affiliation of the person(s), and record his or her perception of the effect of this presence on the course of the examination. The doctor should use his or her judgment as to whether the examination can take place without further risk to the person being examined.

4. Consent to Examination

The doctor should give his or her name and affiliation, explain the purpose of the examination and gain the consent of the subject to the examination if he or she is capable of giving consent. Before consent is obtained, the doctor should inform the subject of the names or posts of all recipients of the medical report.

5. Access to Medical Records
The doctor, and if necessary, a translator, should have access to the subject's previous medical records.

6. Full Examination
The physician's examination should include the elicitation of a full verbal medical history from the subject and the performance of a full clinical examination, including evaluation of the subject's mental state. Further medical, laboratory or psychological investigations, including evaluation of mental health status, should be arranged promptly as deemed necessary by the physician.

7. Report
The physician should promptly prepare an accurate written report. The report should include at least the following four parts:

i. Establishing details—name of the subject and names and affiliations of others present at the examination; the exact time and date, location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house etc)—and the circumstances of the subject at the time of examination (e.g. nature of any restraints used; demeanor of those accompanying the prisoner); and any other relevant factor;
ii. A record of the subject's history as given during the interview, including the time when torture or ill-treatment is alleged to have occurred;
iii. A record of all abnormal physical and psychological findings on clinical examination including, where possible, colour photographs of all injuries;
iv. An interpretation as to the probable cause of all abnormal symptoms and all abnormal physical findings.

The report should clearly identify the doctor carrying out the examination and should be signed.

In the interpretation, the doctor should provide a general assessment of the consistency of the history and examination findings with the nature of the subject's allegations. A recommendation for any necessary medical treatment should also be given.

Where a doctor is unable to finalise the report, whether because of the unavailability of further examination or test results, or for any other reason, this should be stated.

8. Confidentiality of the Report
The subject should be informed of the medical findings and be allowed to inspect the medical report. A copy of the doctor's report should be made available in full to the subject's nominated representative and, where appropriate, to the authority responsible for investigating the allegation of torture. It is the responsibility of the doctor to take reasonable steps to ensure that it is delivered securely to these persons. The report should not be made available to any other person except with the consent of the subject or on the authorization of a court empowered to enforce such a transfer.

9. Second Examination
A second medical examination by an independent doctor should be permitted if requested by the victim of the alleged torture or ill-treatment and/or by his or her representative. The victim of the

alleged torture and/or his or her representative should have the right to nominate the physician who will undertake the second examination. The second examination should be carried out in conformity with these principles.

10. Ethical Duties

The doctor should bear in mind at all times that, in accordance with internationally accepted standards of medical ethics, his or her primary duty is to promote the wellbeing of the patient. In addition, he or she has a duty not to condone or participate in torture or other cruel, inhuman and degrading treatment. No aspect of the subject's character, physical characteristics, ethnic origin, or personal beliefs, nor the fact that an allegation of torture has been made by or on behalf of the subject, permits derogation from these duties.

Appendix 3

Declaration on the Role of Health Professionals in the Exposure of Torture and Ill-treatment

Preamble: Human rights and medical ethics standards have evolved in recent years and, currently, strong legal and ethical prohibitions on torture and other human rights violations exist. These include the United Nations (UN) Universal Declaration of Human Rights, the Declaration on the Protection of all Persons from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration against Torture), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, regional human rights treaties and a number of statements adopted by doctors' and nurses' organizations. Torture and other cruel, inhuman or degrading treatment, however, continues and the need for positive action by health professionals to expose these abuses is as great as ever. The following declaration articulates the steps—implicit in the ethics of medicine and nursing—which Amnesty International believes should be taken by health professionals to fulfil their role as protector of the vulnerable, particularly those deprived of liberty.

Declaration

Amnesty International

Recalling that the Declaration of Tokyo of the World Medical Association (1975) obliges doctors not to condone, countenance or participate in torture;

Recalling that the United Nations 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 or Punishment (1982) states that it is a gross contravention of medical ethics for health personnel, particularly physicians, to assist, actively or passively, in acts of torture;

Further recalling that the International Council of Nurses has declared in The Role of the Nurse in the Care of Detainees and Prisoners (1975) that nurses having knowledge of physical or mental ill-treatment must take appropriate action including reporting the matter to appropriate national and/or international bodies;

Noting the fundamental obligation stemming from the Hippocratic Oath and the World Medical Association's International Code of Medical Ethics (1949) for doctors to practice for the good of their patient and never to do harm*;*

Recalling the important role of health professionals in protecting particular vulnerable individuals such as children through exposing instances of serious abuses coming to their attention;

Recalling that torture and other cruel, inhuman or degrading treatment or punishment are contrary to international law;

Calls on health professionals witnessing torture or other cruel, inhuman or degrading treatment or punishment, or the effects of such violations, to report their observations to their immediate manager and to their professional association. In the event of inaction by the persons so informed (or where, in the judgment of the health professional, it would be too dangerous to report to these persons), the health professional should report his or her observations to an international professional, humanitarian or human rights organization.

Declares that the health professional making such a report should be given support by individual colleagues and by their national and international professional associations. Such associations should take firm action when a health professional is disciplined in any way or otherwise victimised for reporting human rights violations, including making strong representations to the authorities to quash such disciplinary measures and to provide legal assistance to the threatened individual.

Calls on national professional associations to adopt and publicise statements opposing professional involvement in human rights violations and to ensure that their members know of their ethical responsibility to report torture and ill-treatment and of the commitment of the association to support members reporting abuses.

Calls on international professional associations and the United Nations and its relevant agencies to publicise the ethical responsibility of health professionals to report human rights violations inflicted on their patients.

Calls on international professional bodies to make clear statements about the serious breach of professional ethics occasioned by a health professional's purposely omitting, modifying, or falsifying relevant information in the medical history of an alleged victim of torture or ill-treatment, such as to preclude or to make difficult the treatment of the patient, to prevent redress for the victim or to impede the bringing to justice of those responsible for the torture or ill-treatment.

Further calls on international professional bodies to investigate, and where appropriate, impose sanctions on, national associations which collude in the infliction of human rights violations in their countries.

Adopted by Amnesty International, January 1996

Appendix 4:Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions.

(Resolution 1989/65 on the prevention of extrajudicial executions and adequate investigation of such executions was adopted by the United Nations' Economic and Social Council on 24 May 1989 and endorsed by the UN General Assembly in December 1989. The preamble to the resolution is not given here.)

Prevention

1. Governments shall prohibit by law all extra-legal, arbitrary and summary executions and shall ensure that any such executions are recognized as offences under their criminal laws, and are punishable by appropriate penalties which take into account the seriousness of such offences. Exceptional circumstances including a state of war or threat of war, internal political instability or any other public emergency may not be invoked as a justification of such executions. Such executions shall not be carried out under any circumstances including, but not limited to, situations of internal armed conflict, excessive or illegal use of force by a public official or other person acting in an official capacity or a person acting at the instigation, or with the consent or acquiescence of such person, and situations in which deaths occur in custody. This prohibition shall prevail over decrees issued by governmental authority.

2. In order to prevent extra-legal, arbitrary and summary executions, Governments shall ensure strict control, including a clear chain of command over all officials responsible for the apprehension, arrest, detention, custody and imprisonment as well as those officials authorized by law to use force and firearms.

3. Governments shall prohibit orders from superior officers or public authorities authorizing or inciting other persons to carry out any such extra-legal, arbitrary or summary executions. All persons shall have the right and the duty to defy such orders. Training of law enforcement officials shall emphasize the above provisions.

4. Effective protection through judicial or other means shall be guaranteed to individuals and groups who are in danger of extra-legal, arbitrary or summary executions, including those who receive death threats.

5. No one shall be involuntarily returned or extradited to a country where there are substantial grounds for believing that he or she may become a victim of extra-legal, arbitrary or summary execution in that country.

6. Governments shall ensure that persons deprived of their liberty are held in officially recognized places of custody, and that accurate information on their custody and whereabouts, including transfers, is made promptly available to their relatives and lawyer or other persons of confidence.

7. Qualified inspectors, including medical personnel, or an equivalent independent authority, shall conduct inspections in places of custody on a regular basis, and be empowered to undertake unannounced inspections on their own initiative, with full guarantees of independence in the exercise of this function. The inspectors shall have unrestricted access to all persons in such places of custody, as well as to all their records.

8. Government shall make every effort to prevent extra-legal, arbitrary and summary executions through measures such as diplomatic intercession, improved access of complainants to intergovernmental and judicial bodies, and public denunciation. Intergovernmental mechanisms shall be used to investigate reports of any such executions and to take effective action against such practice. Governments, including those of countries where extra-legal, arbitrary and summary executions are reasonably suspected to occur, shall cooperate fully in international investigations on the subject.

Investigation

9. There shall be a thorough, prompt and impartial investigation of all suspected cases of extra-legal, arbitrary and summary executions, including cases where complaints by relatives or other reliable reports suggest unnatural death in the above circumstances. Governments shall maintain investigative offices and procedures to undertake such inquiries. The purpose of the investigation shall be to determine the cause, manner and time of death, the person responsible, and any pattern or practice which may have brought about that death. It shall include an adequate autopsy, collection and analysis of all physical and documentary evidence, and statements from witnesses. The investigation shall distinguish between natural death, accidental death, suicide and homicide.

10. The investigative authority shall have the power to obtain all the information necessary to the inquiry. Those persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige officials allegedly

involved in any such executions to appear and testify. The same shall apply to any witness. To this end, they shall be entitled to issue summons to witnesses including the officials allegedly involved and to demand the production of evidence.

11. In cases in which the established investigative procedures are inadequate because of lack of expertise or impartiality, because of the importance of the matter or because of the apparent existence of a pattern of abuse, and in cases where there are complaints from the family of the victim about these inadequacies or other substantial reasons, Governments shall pursue investigations through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any institution, agency or person that may be the subject of the inquiry. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided under these Principles.

12. The body of the deceased person shall not be disposed of until an adequate autopsy is conducted by a physician, who shall, if possible, be an expert in forensic pathology. Those conducting the autopsy shall have the right of access to all investigative data, to the place where the body was discovered, and to the place where the death is thought to have occurred. If the body has been buried and it later appears that an investigation is required, the body shall be promptly and competently exhumed for an autopsy. If skeletal remains are discovered, they should be carefully exhumed and studied according to systematic anthropological techniques.

13. The body of the deceased shall be available to those conducting the autopsy for a sufficient amount of time to enable a thorough investigation to be carried out. The autopsy shall, at a minimum, attempt to establish the identity of the deceased and the cause and manner of death. The time and place of death shall also be determined to the extent possible. Detailed colour photographs of the deceased shall be included in the autopsy report in order to document and support the findings of the investigation. The autopsy report must describe any and all injuries to the deceased including any evidence of torture.

14. In order to ensure objective results, those conducting the autopsy must be able to function impartially and independently of any potentially implicated persons or organizations or entities.

15. Complainants, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation. Those potentially implicated in extra-legal, arbitrary or summary executions shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as over those conducting investigations.

16. Families of the deceased and their legal representatives shall be informed of, and have access to, any hearing as well as to all information relevant to the investigation, and shall be entitled to present other evidence. The family of the deceased shall have the right to insist that a medical or other qualified representative be present at the autopsy. When the identity of a deceased person has been determined, a notification of death shall be posted, and the family or relatives of the deceased immediately informed. The body of the deceased shall be returned to them upon completion of the investigation.

17. A written report shall be made within a reasonable period of time on the methods and findings of such investigations. The report shall be made public immediately and shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. The report shall also describe in detail specific events that were found to have occurred, and the evidence upon which such findings were based, and list the names of witnesses who testified, with the exception of those whose identities have been withheld for their own protection. The Government shall, within a reasonable period of time, either reply to the report of the investigation, or indicate the steps to be taken in response to it.

Legal Proceedings

18. Governments shall ensure that persons identified by the investigation as having participated in extra-legal, arbitrary and summary executions in any territory under their jurisdiction are brought to justice. Governments shall either bring such persons to justice or cooperate to extradite any such persons to other countries wishing to exercise jurisdiction. This principle shall apply irrespective of who and where the perpetrators or the victims are, their nationalities or where the offence was committed.

19. Without prejudice to Principle 3 above, an order from a superior officer or a public authority may not be invoked as a justification for extra-legal, arbitrary or summary executions. Superiors, officers or

other public officials may be held responsible for acts committed by officials under their hierarchical authority if they had a reasonable opportunity to prevent such acts. In no circumstances including a state of war, siege or other public emergency, shall blanket immunity from prosecution be granted to any person allegedly involved in extra-legal, arbitrary or summary executions.

20. The families and dependents of victims of extra-legal, arbitrary and summary executions shall be entitled to fair and adequate compensation, within a reasonable period of time.

Appendix 5: Extracts of Relevant Ethical Codes

World Medical Association: *Declaration of Tokyo*

"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."

World Medical Association: *International Code of Medical Ethics*

"A physician shall, in all types of medical practice, be dedicated to providing competent medical services in full technical and moral independence, with compassion and respect for human dignity."

United Nations: *Principles of Medical Ethics*

"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."

International Council of Nurses: *The Nurse's Role in the Care of Detainees and Prisoners:*

"Nurses having knowledge of physical or mental ill-treatment of detainees and prisoners must take appropriate action including reporting the matter to appropriate national and/or international bodies."